Maternal and Child Health Services
Title V Block Grant

State Narrative for Louisiana

Application for 2009
Annual Report for 2007

Document Generation Date: Sunday, September 21, 2008

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (504) 568-8162 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
325 Loyola Avenue, Room 612
New Orleans, LA 70112

/2007/
Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (504) 219-4583 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
P.O. Box 60630
New Orleans, LA 70160
//2007//

/2008/
Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (225) 342-2256 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
P.O. Box 3214
Baton Rouge, LA 70821
//2008//

/2009/ Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (225) 342-2256 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section

P.O. Box 3214
Baton Rouge, LA 70821 //2009//

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

Input from MCH stakeholders was facilitated by publishing the MCH priority needs and program activities in the May 2005 issue of the Louisiana Maternal and Child Health (MCH) Coalition News. The 210 members of the Coalition represent public and private hospitals, and obstetric and pediatric providers. The Priority Needs were distributed and the Needs Assessment process discussed at a meeting of the MCH Coalition Board on April 27th, 2005. Questions and comments pertained to Oral Health, local and regional input and involvement in the Needs Assessment process, and the Fetal and Infant Mortality Review (FIMR).

The Title V Application has become more accessible to Louisiana's citizens via Internet access. A summarized version of the application was posted to the MCH website on 5/24/05 (see attachment or www.oph.dhh.state.la.us/maternalchild/index.html). The summary document was reviewed by 30 CSHS Stakeholders from all 9 administrative regions of the state. The Stakeholders suggested that we address access to health care, dental care and transportation; provide ongoing education to CSHS families; address transition of CSHCN to adult services; emphasize mental health issues and ensure healthy pregnancies.

/2007/The MCH Program Plan was distributed to the MCH Coalition and CSHS Stakeholders. Recipients were asked, in the context of the hurricanes, what changes they would like to see in the MCH program. Feedback included the needs of families in Special Needs Shelters, and statewide access to CSHS medical records. The Summary website was updated and a notice of the grant was posted to the Louisiana Register.//2007//

/2008/ Input from MCH stakeholders was facilitated by publishing the MCH priority needs and program activities in the May 2007 issue of the Louisiana Maternal and Child Health (MCH) Coalition News. Recipients were asked for feedback. The MCH Program Plan was distributed to CSHS Stakeholders. The Summary of the Block Grant was updated and posted to the MCH website on June 15, 2007and a notice of the posting of the grant was published in the Louisiana Register in June 2007.//2008//

/2009/ Input from MCH stakeholders was facilitated by publishing the MCH priority needs and program activities in the Louisiana Maternal and Child Health (MCH) Coalition News, and a presentation provided to the Coalition Board members. Recipients were asked for feedback. The Summary of the Block Grant was updated and posted to the MCH website on May 5, 2008 and a notice of the posting of the grant was published in the Louisiana Register in May 2008. (see attachment) The summary document was reviewed by CSHS Stakeholders from all 9 administrative regions of the state. The Stakeholders suggested that we strongly emphasize the link or association between good prenatal care and children born with special health care needs. //2009//
An attachment is included in this section.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

An attachment is included in this section.

C. Needs Assessment Summary

Following the 2005 needs assessment process, the MCH and CSHS staff created the following priority needs for Louisiana's Title V Block Grant: (1) Decrease infant mortality and morbidity in collaboration with regional coalitions comprised of public and private health and social service providers; (2) Decrease intentional and unintentional injuries in the maternal, child, adolescent, and children with special health care needs populations; (3) Assure access to quality health care for the maternal, child, adolescent, and children with special health care needs populations, addressing barriers including Medicaid provider availability and lack of transportation; (4) Address the mental health needs of the maternal, child, adolescent, and children with special health care needs populations, through prevention and early intervention, screening, referral, and where appropriate, treatment; (5) Address the substance abuse related needs of the maternal and adolescent population, through prevention and early intervention, screening, and referral; (6) Promote comprehensive systems of care and seamless transition to adult services for the Children with Special Health Care Needs population by providing care coordination. (7) Promote pre-conceptional and inter-conceptional health care including family planning; (8) Address the oral health needs of the maternal, child, adolescent, and children with special health care needs populations; (9) Improve the health behaviors of the maternal, child, adolescent, and children with special health care needs populations, addressing healthy nutrition, proper prenatal weight gain, breastfeeding, and physical activity; (10) Obtain and utilize reliable evidence to: a) identify preventable causes of maternal, child and adolescent mortality and morbidity, b) develop preventive public health campaigns targeting high risk populations, and c) perform process and outcome evaluation.

Priority action steps and progress made with respect to each priority need is carefully reviewed every 3 months by key MCH stakeholders and program staff to assure that each remains a top priority for the Louisiana MCH Program. There has been no change in the top 10 priority needs for the MCH Program since the 2005 needs assessment. However, selected activities related to these goals have been updated or modified as appropriate and necessary to improve health in Louisiana based on input and experience from MCH Program staff and stakeholders.

The Maternal and Child Health (MCH) Program formed a needs assessment steering committee to discuss and plan the 2005 Title V Needs Assessment process. The steering committee decided to organize the needs assessment process into five subgroups: Adolescent Health, Child Health, Perinatal Health, Oral Health, and Children with Special Health Care Needs.

An update of the perinatal needs assessment is planned for Fall 2007 through Spring 2008. New data from vital records, PRAMS, and other programs will be shared with each of the 9 regions across Louisiana to assure that current priority needs are being addressed state-wide. An oral health screening of 3rd graders by school health nurses is planned for this year to determine dental sealant prevalence among these children. Results will be available in the next block grant year. In the Summer of 2006, a Graduate Student Intern (GSIP Program) assisted CSHS staff with a revised needs assessment to re-evaluate program activities post-hurricanes. This effort was finalized in the Fall by the CSHS epidemiologist and CSHS Medical Director. Internal data from the CSHS program was used to assess current resource allocation and utilization, and results were presented to CSHS stakeholders to help guide program planning for the 2007-08 years. Findings suggested that access to physicians was hindered in hurricane-affected areas, leaving some CSHS needs unmet for several months. It is believed that either services in these

areas have returned to pre-hurricane capacity or that the CSHS population has relocated such that the majority of known needs are being met. Access to care may have improved recently due to extensive outreach efforts targeting Medicaid enrollment of CSHS eligible individuals. No changes in program priorities resulted from the revised needs assessment.
Infant mortality, low birth weight, prenatal care, care coordination, oral health, intentional and unintentional injury remain focus areas of the MCH Program. The Oral Health program received funding for additional staff to work with priority activities targeting improved oral health in the MCH population. Recent revision of Injury Program staff within OPH provides new opportunity for targeted injury prevention outreach and education. Assuring access to primary care providers, for both the uninsured and Medicaid populations, also continues to be a major focus of the MCH and CSHS Programs.

New areas have emerged as priorities. These include Mental Health (Priority Need #4) and Substance Abuse (Priority Need #5). Additional funding for a perinatal depression counselor for high-risk women has allowed for improved capacity in the areas hardest hit by hurricane Katrina. Collaborative efforts with the Office of Mental Health and the Office for Addictive Disorders has lead to a joint effort to initiate use of a validated substance use and depression screening tool, the 4ps plus, along with a model for brief intervention and referral for clients who screen positive. This program is currently in place in 4 of the 9 public health regions (3 beginning within the past 2 months), and Medicaid will consider reimbursement for this screening/brief intervention once the program has been implemented state-wide. Both of these initiatives have incorporated strong program evaluation efforts to assure that these programs are achieving their stated goals. Results of this systematic data collection are expected in 1-2 years.

/2009/ Priority needs continue to be reviewed multiple times per year to assess progress and identify new opportunities. While no changes are reported in the top 10 MCH priority needs, selected activities implemented to address these needs have been updated or modified to continue effecting positive change. All MCH Programs strive to effectively address cultural diversity in the development of appropriately designed messages and interventions. //2009//
An attachment is included in this section.

III. State Overview

A. Overview

/2007/ Louisiana's already poor health status took a tremendous blow from Hurricanes Katrina and Rita. As a result of both Hurricanes Katrina (August 29, 2005) and Rita (September 24, 2005), southeastern and southwestern Louisiana sustained unprecedented and extensive devastation of epic proportions. More than three million people were impacted and more than 1,300 lost their lives. The population in New Orleans has been reduced from 450,000 to a current population of about 185,000. The combined damage of the storms range from $100-$200 billion due to, but not limited to, the loss of homes, communities, businesses, jobs, schools, and significant impairment the state's healthcare infrastructure. The state's pre-existing health status and infrastructure problems coupled with the new post-hurricane provider exodus, population shifts and extensive damage to the pre-existing impaired healthcare system and communities, create huge challenges for the state health care delivery systems.

Both the private and public sector healthcare infrastructure sustained extensive damage from the storms, exacerbating challenges to the delivery of Title V services and all other healthcare services statewide. Louisiana's healthcare industry is currently functioning at or below 50 percent capacity as a result of the storms' devastation. Statewide, there was a loss of patients, more than 6,000 trained medical personnel, medical/dental clinics, hospitals (including the Medical Center of Louisiana's Charity Hospital, the Level 1 Trauma Center and public health hospital in New Orleans), pharmacies, medical/dental and other healthcare services, health information/medical records (continuity of care), and scientific research. Also of importance were the loss and/or disruption of medical, dental, pharmacy, and allied health education and training programs. /2008/ A study conducted by the LSU Public Policy Research Lab estimated that the total number of uninsured residents as of fall 2006 was 657,027. The 2006 Louisiana Health and Population Survey estimated that approximately 669,000 people reside in Region 1 compared to 1,000,000 prior to hurricane Katrina. The survey also estimated that 124,592 of these residents do not have any form of health insurance (estimated at 160,000 pre storm). Prior to the storm, 245,000 residents in the region were enrolled in Medicaid; February 2007, about 134,821 Region 1 residents were enrolled in Medicaid.//2008// ***/2009/ The Annual Louisiana Medicaid Report for State FY 2006-07 estimated that ~35% of Orleans, Jefferson, Plaquemines, St. Bernard Parishes residents and ~27% of Louisiana residents were enrolled in Medicaid. //2009//***

The healthcare infrastructure of the Department of Health and Hospital's Region 1, which includes Orleans, Jefferson, St. Bernard, and Plaquemines Parishes was, and still remains, the most devastated. Orleans Parish had one of the largest concentrations of primary care providers and other health professionals in the state prior to Hurricane Katrina. As of April 2006 , the DHH Bureau of Primary Care and Rural Health has determined that Orleans Parish now has less than one primary care physician for every 3,200 residents, less than one psychiatrist for every 21,000 residents and less than one dentist for every 5,000 residents. Available acute care hospital beds remain at approximately 50 percent, and there is still a shortage of trauma, ambulatory care, and mental health services. The need for mental health services throughout the state has grown exponentially since the storms. Due to the population changes and the limited availability of health care services post-Katrina, New Orleans has been designated as a health professional shortage area (HPSA). Therefore, post-Katrina, the state's total Health Professional Shortage Areas (HPSA) designations are 404: primary care (243), mental health (108), and dental health (53), and they are located throughout the 64 state parishes, as of June 2006. /2008/ Currently, about 86% of Louisiana parishes are designated health professional shortage areas. The estimated provider shortage in Region 1 has a gap of 54 primary care physicians needed to treat the Medicaid and uninsured populations, 42 dentists for the Medicaid population, 10 psychiatrists for the general, uninsured and Medicaid populations, and 53 pharmacists for the general population.//2008// ***/2009/ Louisiana has 257 HPSA designations for primary care, 154 for oral health, and 60 for mental health. //2009//***

The Louisiana Recovery Authority (LRA) is charged with post-hurricane healthcare reform and serves as the planning and coordinating body created in the aftermath of the hurricanes by the Governor. LRA Public Health and Healthcare Taskforce contracted with Price Waterhouse Coopers to assist with state health planning efforts post-Katrina. The key findings and recommendations presented in their "Report on Louisiana's Healthcare Delivery and Financing System" include: quality issues; removing the 2-system (public and private) model; address the impacted area's immediate need including long term care, mental health, trauma, and ambulatory care; address divergent interests between the LSU academic medical center and the other public hospitals; address the 2-system model impact on graduate medical education; 6 address shortage of primary care physicians and oversupply of specialty physicians; address shortage of registered nurses and allied health professionals; improve information technology infrastructure; address need for statewide health care emergency preparedness system including incorporating on-site preventive care and other health services into transitional housing communities' service delivery plans.

The DHH Bureau of Primary Care and Rural Health has been charged with making recommendations for redesigning and rebuilding the healthcare infrastructures in the impacted regions of the state. One approach is through community planning to restore access to healthcare services in the impacted areas, with a focus on integrative primary and preventive healthcare and behavioral healthcare services. ***/2009/ The LA Healthcare Quality Forum (LHCQF) was legislated in 2007 to facilitate a Medical Home (MH) system of care statewide. LHCQF adopted the National Committee for Quality Assurance Patient Centered MH Guidelines as the standard. In May 2008 the forum held a MH Summit for policy makers, where CSHS presented its Model MH Care Coordination (CC) findings. DHH has proposed adopting Florida's model of Provider Service Networks (PSN) with capitated Medicaid for CSHCN statewide. //2009//***

Despite some improvements from reform efforts, Louisiana still ranks as one of the three unhealthiest states for children. Poverty, inadequate income, and low education levels are just a few contributing factors affecting the state and the Title V Program's overall priorities, healthcare initiatives, and delivery of services. According to the 2005 KIDS COUNT Data Book, Louisiana was ranked 49th in the nation for its children's health status and well-being based upon 2004 data. Louisiana ranked the worst (50) for percent of teens not attending school and not working (ages 16-19); percent of children living in families where no parent has full-time, year--round employment; and percent of children in single-parent households. Louisiana was near the bottom ranking (49) for percent of low-birthweight babies and children in poverty. Compared to the previous year of data, Louisiana saw improvements in infant mortality, the child death rate and the percent of high school dropouts. It also saw a slight decline in the teen death rate. Teen births were not ranked in the 2006 report but Louisiana was 49th based upon 2002 data. The percent of children in poverty remained unchanged at 30% from 2003 to 2004. The negative economic impact of Hurricanes Katrina and Rita due to the loss of jobs, which resulted in the loss of income and health insurance; the loss of schools, which resulted in the loss of educational opportunities and eventually the opportunities for higher wage jobs; and the loss of healthcare providers/facilities, which resulted in the loss of healthcare access, will have a negative impact on the health status of our children in Louisiana. The degree of the impact has yet to be determined. /2008/ Louisiana ranked 50th in the nation for infant mortality (2004 data) and 49th in the nation for overall children's health status (2004 data), low birth weight babies (2004 data), children in poverty (2005 data), children in single-parent families (2005 data), and children living in families where no parent has full-time, year-round employment (2005 data). Louisiana ranked 47th (2004 data) in child deaths, 45th in teen deaths from all causes (2004 data), 40th for teens not attending school and not working (2005 data), and teens who are high school dropouts. Compared to prior year's data, Louisiana saw improvements in teen births; teens who are high school dropouts; teens not attending school and not working; children in poverty; and children in single-parent families.//2008// ***/2009/ The 2008 KIDS COUNT Data Book, ranks Louisiana 49th in the nation for the health status and well-being of children (2005/06 data). Louisiana ranks 48th for teens not attending school and not working (2006 data); 49th for infant mortality (2005***

data), low birth weight babies (2005 data), teen deaths from all causes (2005 data), children in poverty (2006 data), children in single-parent families (2006 data); and 50th for child deaths (2005 data), teen high school dropouts (2006 data), and children living in families where no parent has full time, year-round employment (2006 data). Improvements were seen in infant mortality, teen births in all age groups; and children in single-parent families. //2009//

Though Louisiana is ranked as one of the unhealthiest states, positive strides were being made in healthcare reform efforts prior to the storms. Louisiana had moved from last place (50th) in 2005 to 48th place, according to the 2006 Morgan Quitno National Report on states' healthcare status rankings. Of the 21 health status indicators, Louisiana improved its ranking on 13 factors. One of the areas where Louisiana showed the most improvement was on the percentage of children who do not have health insurance coverage. Louisiana improved 27 places and is now ranked 33rd nationwide. The reduction in the number of children without health insurance from 11 percent to 7.6 percent, and resulted from aggressive and targeted outreach efforts by Medicaid and LaCHIP staff, through the Louisiana Covering Kids Initiative. Targeted outreach resulted in the enrollment of more than 55,000 children over the last two years. With the national average being 12 percent and with the state's average being 7 percent, Louisiana is now one of the top 10 states with the lowest uninsured rates for children. Louisiana also improved its ranking on childhood immunizations. The state moved up three ranking positions and increased the number of children immunized by nearly 4 percent. Based on 2005 data from the parish health units, 66 percent of the children ages 19-35 months were up to date on their immunizations, which reflect an increase of 12 percent from 2004. The LINKS system, which tracks childhood immunizations in the state, is credited for improving this ranking. /2008/ The 2007 Morgan Quitno Report ranked Louisiana as the unhealthiest state in the nation. According to DHH, Louisiana is ranked 6th in the nation in the percent of the population lacking access to primary care; and 3rd highest in the percentage of uninsured residents in the nation at 19%. Almost 50% of Louisiana residents live at or below 200% of the federal poverty level, and 25% of Louisiana residents live in rural areas, but only 14% of primary care physicians practice in rural areas.//2008// ***/2009/ Louisiana is the second unhealthiest state in the nation according to the 2008 Morgan Quitno Press. //2009//***

Racial and ethnic disparities, like poverty, negatively impact the health and social-emotional wellness of Louisiana children. According to the US Census 2004 American Community Survey, the percent of African American families living below poverty level is 29.9%, compared to 16.7% Hispanic, 3.5% Asians, and 8.2% Caucasian families. Overall, the infant mortality rate increased from 9.3 deaths per 1,000 live births in 2003 to 10.4 deaths per 1,000 live births in 2004. Though there was an increase for both whites, from 6.4 to 7.7 deaths per 1,000 white births, and blacks, from 13.8 to 14.7 deaths per 1,000 black births from 2003 to 2004, the infant mortality rate for blacks is twice that of whites. In 2004, despite the increase in the percent of black women receiving prenatal care in the first trimester, from 75.5% to 79.2%, the percentage was significantly lower than the 91.6% of white women who received prenatal care in the first trimester. Despite the overall decrease in SIDS deaths in 2004 to 0.8 deaths per 1,000 live births, the rate for black infants, at 1.0 deaths per 1,000 live births, is still higher than the rate for white infants, which is at 0.7 deaths per 1,000. Reducing racial and ethnic disparities in the health status of mothers, children, and families is a priority of Louisiana's MCH Program. /2008/ According to the US Census 2005 American Community Survey, the percent of African American families living below poverty level in Louisiana is 32.3% compared to 17.9% Hispanic, and 8.7% Caucasian families. Preliminary 2005 state vital records data shows that Louisiana's infant mortality rate decreased to 10.0 deaths compared to 10.4 deaths per 1,000 live births in 2004. The percentage of infants born to pregnant women receiving prenatal care in the first trimester improved to 87.2% in 2005. Reducing racial and ethnic disparities, which negatively impact the physical, mental, and social-emotional wellness of children and families, remains a priority of Louisiana's MCH Program.//2008//

The aftermath of the hurricanes posed many other unique challenges for the state and the Title V MCH Program. There has been large population shifts within the state and out of Louisiana due

to mass evacuation. Initially, more than a million people evacuated the southeastern and southwestern parts of the state for Hurricanes Katrina and Rita. Because repopulation and rebuilding are very slow in the heavily storm impacted areas, much of evacuated MCH population remains dispersed. Therefore, outreach efforts have increased to locate high risk MCH populations and identifying new populations. There is an influx of uninsured, undocumented, and non-English speaking workers and their families into the impacted areas of the state, which has very limited support services available and a very impaired and strained healthcare system. Housing for families in the impacted areas are very limited, unsafe (moldy, gutted), or unaffordable. Families are adjusting to living in trailers instead of homes and, in some cases, living in the federalized transitional housing (trailer) communities, which are very restrictive. Limited access to transportation, a challenge before the storms, has worsened post-hurricanes due to the loss of public transportation in such impacted areas as Orleans and Jefferson Parishes; the loss of personal vehicles to flood waters; and/or relocation of residents to rural areas where there is very limited or no access to public transit.

MCH and public health has continued to function as the "safety net" for healthcare services, despite the state's fiscal constraints and budgetary cuts to state MCH funding. Title V services continue to be a primary resource for prenatal care, preventive pediatric, and subspecialty pediatric services in certain areas of the state, especially after the storms. For example, Title V funds help to support the only prenatal maternity services available for the uninsured of Orleans, Plaquemines, and St. Bernard Parishes since Hurricane Katrina, which is offered through the Jefferson Parish Public Health Unit. Additionally, the MCH Program has continued to monitor the health status of Louisiana's mothers and children and has developed, expanded, and/or supported programs targeting those areas of the State with the greatest MCH needs through outreach to low-income pregnant women and children; public education campaigns; newborn screening; lead poisoning and injury prevention; oral health services; services for children with special health care needs; and support of contracted delivery of services by primary care centers, hospitals, medical schools and other community-based organizations in those areas.

The challenges facing Louisiana's healthcare system are many, but not impossible to overcome. Louisiana has an opportunity to rebuild its healthcare system and improve the health of all residents statewide. The MCH Program will actively participate in this rebuilding process to ensure that the healthcare needs of low income women, infants, and children are met. Operating within the context of the Office of Public Health and the changing health care environment, the Title V Program maintains its commitment to decreasing mortality and morbidity and assuring access to primary and preventive health care services for Louisiana's maternal and child health population including those with special health care needs. //2007// ***/2009/ Louisiana has a new Governor, Director and Deputy Director of Health, and Assistant Secretary of Office of Public Health. Proposals for much needed reform to Louisiana's behavioral health care system include a mental health crisis safety net infrastructure with a single point of entry, telemedicine use in provider shortage areas, and community-based system of care. The lack of providers trained in infant and child mental/behavioral health persists. //2009//***

Louisiana is unique because of its history of a comprehensive publicly financed health care system to serve its large proportion of poor citizens. In the past, Louisiana has relied heavily on its regional, State-supported hospital system and large network of Maternal and Child Health (MCH) Block Grant and other federal and state funded public health clinics to directly provide preventive and primary health care for pregnant women, infants, children, and adolescents, as well as services for children with special health care needs, for its large medically indigent population. Maps 1, 2, and 3 of the attachment show existing Parish Health Units, State Charity Hospitals, and Federally Qualified Health Centers (FQHC), respectively. Additionally, the MCH Adolescent School Health Initiative began in the early 1990's and provides support for primary and preventive physical and mental health services in 54 state-funded, 1 federally-funded, and 1 private- foundation funded school-based health centers across the state. /2008/ There are currently 50 School Based Health Centers across the state. Six centers closed due to the hurricanes and 5 were in New Orleans.//2008// ***/2009/ Lousiaiana has 56 SBHC in 23 parishes***

serving 86 public schools and 20 Federally Qualified Health Centers, with 56 service sites. //2009//

Changes in the financing of health care services through the State system and the infrastructure of health department services have occurred in the past decade, which have affected the role of Title V in the health care system within the state. Since the Omnibus Reconciliation Act of 1990, Medicaid reimbursement for obstetric and pediatric care has increased, resulting in a growing participation of private physicians and hospitals in providing health care to Louisiana's low-income poor women and children. More recently, the State Medicaid Program has enacted several changes that have had a positive impact on financing health services for the low-income population. These include expansion of income eligibility for Medicaid through the State Child Health Insurance Program (LaCHIP), expanded income eligibility for pregnant women (LaMOMS), and statewide implementation of a primary care case management program for Medicaid recipients (Community Care). This has resulted in a decrease in the need for direct services through the public health units. Simultaneously, over the past several years, the state has experienced budget shortages that have impacted the services provided through the Department of Health and Hospitals. Ongoing budget shortages have resulted in hiring and spending freezes for all government agencies, restrictions on purchases, contracting, out of state travel, and cuts to contract expenditures. Since 2000, the Office of Public Health (OPH) has experienced a lay-off resulting in approximately a 10% reduction of the entire agency workforce and discontinued the staffing of 25 parish health units with the turnover of 18 of these units by contract agencies including primary care centers or hospitals. Since 2003, the management of Part C of the Individuals with Disabilities Education Act (IDEA) by the Children's Special Health Services (CSHS) program has been very successful with a 43% increase in children from birth to 3 years identified with developmental disabilities. The success of the program with a resulting increased enrollment and demand for services has lead to a significant increase in expenditures, which has put a strain on the entire Office of Public Health budget. This has resulted in budget constraints for all programs and a restructuring of the Part C program, called EarlySteps, emphasizing cost containment. ***/2009/ The LaCHIP Affordable Plan is the new Medicaid health insurance program for uninsured children in families whose gross income is between 200 and 250 percent FPL. //2009//***

The reduction in staff has affected the MCH and CSHS Programs in several ways; one being a decrease in the number of MCH and CSHS visits. A comparison of visits in 2004 compared to 2003 shows a 7.8% reduction in child health visits and an 8.9% reduction in maternal health visits. However, the number of pregnant women and children receiving WIC and women receiving pregnancy testing services in parish health units increased from 129,031 to 137,144. The number of children served by CSHS continues to show gradual decline from 5,792 in 2002 to 5,360 in 2004. However, the number of clinic visits has remained stable, indicating that children with multiple special needs and more severe medical conditions are enrolled in the program. Enrollment in CSHS is also affected by income and eligibility criterion that has not changed in over 20 years. The CSHS program has completed 2 years of implementation of the EarlySteps program. This early intervention program has increased the staff and capacity of Title V in Louisiana in identifying and providing services to Children with Special Health Care Needs (CSHCN) and in establishing closer working relationships with other state agencies, parent advocacy groups and families.

/2008/ In 2006 CSHS clinics had 16,513 visits. This is a 6.9% drop in activity from the previous year, corresponding to an 8.7% decrease in patient numbers statewide. Efforts to enroll CSHCN in Medicaid have increased options in the private sector for many families. Transportation issues, refusal of about 50% of pediatricians and family practitioners to take Medicaid and/or CSHCN, and lack of sub-specialists in many areas of the state have continued to promote barriers. Region I lost approximately 28.9% of its patients and region V 14.3%.//2008// ***/2009/ According to the National Survey of CSHCN (NSCSHCN), between 2002 and 2006 there was a decrease in children of 9.4% and in CSHCN of 19.4%. Many families of CSHCN chose not to return after the hurricane. In CSHS clinics patients decreased to 4645 but visits***

increased to 17,874. CSHS serves more CSHCN in the private sector through CC, increasing by 9.1% the total number of patients served to 11,167. With addition of more CC's, this will increase rapidly. //2009//

Recent national events have impacted public health in the area of emergency preparedness for natural and man-made disasters with a primary focus on bio-terrorism. State and National sources of funding have been used to build public health infrastructure. Approximately 50 new positions in the Office of Public Health have been added. The presence of these new staff in the areas of epidemiology, bio-terrorism coordinators, laboratory, and hospital nurse coordinators will have an overall impact of strengthening public health services. An example of how these efforts will complement Title V efforts is the use of a planned drill to test our capacity for mass immunizations as a focused community-based effort to provide childhood immunizations, which will impact our immunization rates.

Health Care Reform at the State and local level has been an issue addressed by the new Governor who took office in 2004. Utilizing information from Regional Summits with input from providers and citizens, the first Health Care Summit was held in March 2004. From this Summit has come initiatives to address the following areas: 1) Provide care to the uninsured which includes intensified outreach activities for LaCHIP, adult Medicaid outreach, looking at federal waiver opportunities, and obtaining a state planning grant to develop other options for providing access to affordable health insurance coverage; 2) Access to appropriate health care resources including transportation, improving access to Medicaid for pregnant women, and improving access to treatment services for addictive disorders; 3) Improving and restructuring long -term care, 4) Health education and awareness related to tobacco, obesity, and improving health in schools; 5) Improving administrative delivery of health care including the development of electronic Medicaid files and electronic prescribing and medical records; 6) Focus on performance outcomes using evidenced-based principles including the development of disease management initiatives and the development of decision support tools for Medicaid providers; 7) Reducing prescription drug costs and improving prescribing practices; and 8) Evaluation of the Medicaid Program. Regional Panels have been established to address these issues at the local as well as the State level. These Health Care Reform activities should have a significant long-term impact on the health care system in the state.

Nonetheless, even with improved financing of health services and changes in the public health delivery system, the need for MCH services continues. There remain areas where the Title V services continue to be a primary resource for prenatal care, preventive pediatric, and subspecialty pediatric services. Title V funds provide the wrap-around services for women and children receiving benefits from the Supplemental Food Program for Women, Infants, and Children (WIC) through 70 parish health units. These services include immunizations, prenatal and parenting education, case management, and referral for other health and social services. Although the numbers of women and children served through these clinics have decreased, services were provided to over 137,000 pregnant women and children, comprising a large percentage of the state's population of pregnant women and low income children under 5. Additionally, the MCH Program has continued to monitor the health status of Louisiana's mothers and children and has developed programs targeting those areas of the State with the greatest MCH needs. The savings in MCH funding resulting from the lay-off has been used to contract for the delivery of services by primary care centers, hospitals, medical schools and other community-based organizations in those areas. Thus, the Title V Agency continues to play the role of assuring access to needed services for the State MCH population.

1. Health Care Needs of the State's Population

Louisiana has ranked poorly on national comparisons related to health status and care. A 2005 national report published by Morgan Quitno Press titled "Health Care State Rankings 2005" ranked Louisiana 50th, worst in the nation in health indicators. The report is based on 21 factors that reflect access to health care providers, affordability of health care, and the generally health of the population. Examples of factors include births to teenage mothers, percent of population not

covered by health insurance, death rate, and the sexually transmitted disease rate. Louisiana's ranking as the unhealthiest states stems from its high rate of uninsured, low rate of physical activity, high rate of diabetes, high infant mortality rate, high cancer death rate, and high rate of low birth weight babies. According to the 2004 National Kids Count Report, Louisiana ranks 49th of all states on indicators of child well-being. Although improvements occurred in 5 of 10 of the indicators, Louisiana ranked 49th for percent of low-birth weight babies and for percent of families headed by a single parent and 48th for infant mortality rate, percent of children in poverty, and percent of children living where no-parent has full-time, year-around employment. On the national CSHCN Survey (SLAITS), Louisiana was found to have the 2nd highest percentage in the United States (U.S.) of CSHCN, suggesting that poor health indicators and general health of citizens results in a significantly higher than average percentage of children with special needs. ***/2009/ In NSCSHCN, LA decreased among states from 2nd to 26th in prevalence of CSHCN, from 14.8% to 15.8% of children. //2009//***

a. Louisiana population
According to the US Census from 2000 to 2003, the total population of Louisiana grew by 1.0% to an estimated 4,496,334 people. In terms of racial make up, Louisiana has two main racial groups, white 63.9% and black 32.5%, with 3.6% as other. This is vastly different from the racial make up of the U.S., where 75.1% of the population is white, 12.3% of the population is black, and 12.6% is other. (Figures 1, 2 and 3) The total number of women of childbearing age has decreased from 1,006,947 (22.5%) in 2000 to 983,257 (21.9%) in 2003. Teenagers 15-19 years and children 0-14 years comprised approximately 7.7% and 21.6% of Louisiana's population in 2003. The parish population estimates from 2000 to 2004 can be found in Table 1 of the attachment. /2008/ According to the US Census, the population decreased by 4.87% to 4,287,768 in 2006. In 2005, racial makeup in Louisiana was about 64% white, 33% black, and 3% other, compared to a racial makeup of about 80.2% white, 12.8% black, and 7% other in the U.S. The total number of women of childbearing age decreased from 971,997 (21.6%) in 2004 to 898,065 (20.9%) in 2006.//2008//

Although 72.6%, of the of the state's population lives in an urban setting, geographically Louisiana is a predominantly rural state. Only 27% of the 64 Parishes have at least 70% of their population classified as urban (2000 U.S. Census). Six of those parishes are located in the greater New Orleans metropolitan area. Most of the parishes in the Central and Northern parts of the State are rural. /2008/ According to USDA-ERS data, in 2006, an estimated 26.5% (1,137,845) of Louisiana's population was classified as rural and 73.5% (3,149,923) as urban.//2008//

In 2003, the Bureau of Economic Analysis reported Louisiana a having a per capita personal income of $26,038 compared to the national average $31,459. This shows an increase of 2.9% from 2002. Over the past 3 years, 2000 to 2003, Louisiana has had relatively no change in its median household income of $34,307. The unemployment rate, reported by the Louisiana Department of Labor, in March of 2005 was 5.3% compared with a national rate of 5.2%. The overall poverty rate has not significantly changed in the past four years, 2000-2003. In 2003, Louisiana had an overall poverty rate of 17% or approximately 750,000 people. According to the U.S. Census Bureau, Louisiana had the 4th highest poverty rate in the U.S. for the period 2001-2002. Among the 50 states, Louisiana ranked 47th in child poverty. Only three states, West Virginia, Arkansas, and New Mexico had child poverty rates higher than Louisiana's rate of 25.5% in 2004. The 2004 national rate is 17.6% (United Health Foundation Rankings). /2008/ In 2005, the median household income increased to $36,729 compared to $46,242 U.S. average. According to the 2005 American Community Survey, Louisiana ranked 2nd highest in the nation for overall poverty, with a rate of 19.8% and 3rd highest for children under 18 years in poverty, with a rate of 28.4%. The 2005 U.S. child poverty rate is 17.6% (United Health Foundation Rankings).//2008//

According to the 2000 Census, of the 64 Louisiana parishes, 19 have poverty rates greater than 25% with 3 with rates greater than 35%. Fifteen of these parishes are in the northern and central parts of the State. According to census data, 22.1% of families, with related children less than 18

years, live in poverty, as do 26.7% of families with related children under 5 years. According to the Census 2000, the Louisiana poverty rate for children aged 5 to 15 with disabilities was 35.3%, compared to 25.0% for those without disabilities. In the U.S., 25.4% of children with disabilities aged 5 to 15 lived in households with income below the poverty level, compared to 15.7% of children without disabilities. /2008/According to the 2005 American Community Survey, 24.1% of families with children less than 18 years and 26% of families with children under 5 years live in poverty. The Louisiana poverty rate for children aged 5 to 15 with disabilities was 37.23%, compared to 26.96% for those without disabilities. In the U.S., 28.74% of children with disabilities aged 5 to 15 lived in households with income below the poverty level, compared to 17.04% of children without disabilities.//2008//

Also impacting on the status of Louisiana's mothers and children have been changes in Louisiana's cash assistance program related to welfare reform such as limiting welfare benefits to two years in any five years; capping benefits at five years in a lifetime; and requiring twenty hours per week of work or work training, unless exempt. This has led to an 82% decrease in the number of monthly cash assistance recipients to 22,612 from July 1998 to March 2005 through the Families in Temporary Assistance Program (FITAP) operated by the State Department of Social Services (DSS). In March 2005, 17,448 or 77% of the 22,612 FITAP recipients in the state were children and 5,164 (23%) were adults. Thus far during State Fiscal Year 2004-2005, an average of 12,659 grants were paid each month with the average grant being $194.67. A survey done in 2003 by the Department of Social Services of 2000 families at or below 200% of Federal Poverty level found that more than half of respondents who completed FITAP were still in poverty. Almost 36% of those completing the 24-month program reported income at or below 50% of poverty, and another 32% reported income between 51-100% of poverty.

Low education levels are also a problem in Louisiana. Data from the 2000 census indicates that 32% of the State's population over age 25 years had only a 12th grade education with 9.3% having less than a 9th grade education. /2008/ In 2005, 80 percent of people 25 years and over had at least graduated from high school; 21 percent had a bachelor's degree or higher; and about 6.8% had less than a 9th grade education.//2008//

b. MCH Health Status Indicators

Between 2000 and 2003, Louisiana experienced a 4.6% decline in the number of live births; most of the decrease (3.9%) in live births occurred between the years 2000 and 2001. In 2001, 2002 and 2003 Louisiana had 65,193, 64,755, and 64,689 births respectively. The infant mortality rate in Louisiana decreased from 10.2 in 2002 to 9.3 in 2003; this is the first decrease in Louisiana's infant mortality rate since 2000 and reverses the upward trend that had been seen since 2000. The black infant mortality rate of 13.8 is twice that of the rate of 6.4 for white infants (Figure 4). Disparities in the infant mortality rate are seen when looking at the nine different regions of the state (Figure 5). These disparities are reflective of differences in socioeconomic status and resource availability throughout the State with the poorer and more rural northern and central portions of Louisiana having worse indicators. /2008/ From 2004 to 2005, Louisiana experienced an 8.5% decline in the number of live births, with 64,956 and 59,446 births respectively. The infant mortality rate in Louisiana has increased from 9.3 in 2003 to 10.4 in 2004. The preliminary rate for 2005 is 10.0. Rural, northern, and central portions of Louisiana have the higher rates.//2008// ***/2009/ Preliminary 2006 state vital records data shows a decrease in Louisiana's infant mortality rate (IMR) to 9.7 deaths from 10.1 deaths per 1,000 live births in 2005. //2009//***

Very low (VLBW) and low birth weight (LBW) are major risk factors associated with infant mortality. There has been very little change in the VLBW and LBW rates in Louisiana. In 2003, the VLBW rate was 2.2% and the LBW rate was 10.7%. In the black population, 15% of all births were LBW compared to 7.7% in the white population. This racial disparity can also be seen in the VLBW rate (black=3.5%, white=1.2%). (Figure 6 and Figure 7) See Section II. E., the Outcome Measures narrative, for more information on infant mortality and racial disparities in infant mortality. /2008/ Preliminary 2005 data shows the VLBW percent at 2.3%, with the percentage of

black and white women at 3.6% and 1.4%, respectively. From 2003 to 2004, the percentage of LBW increased from 10.7% to 11.0%, and the percentages increased for black (15.0% to 15.2%) and white (7.7% to 8.0%) women. Preliminary 2005 data shows the percent LBW at 11.5%, with 16.0% for black and 8.6% for white women.//2008//

Prior to 2000, Louisiana experienced an overall decreasing trend in the child death rate. However, since 2000, the rate has increased from 30.8 deaths per 100,000 children to a rate of 34.8 deaths in 2002. Data for 2003 shows the increasing trend may be reversing with a child death rate of 26.5. Louisiana's child death rate remains higher than the 2002 national rate of 21.4 deaths per 100,000 children. The leading cause of deaths in children aged 1 to 14 was unintentional injury followed by congenital anomalies and homicide. Motor vehicle crash (MVC) deaths accounted for the largest number of unintentional injury deaths with fire and drowning the second and third leading causes. The 2004 Kids Count report ranked Louisiana 46th for violent deaths by accident, homicide, and suicide, for adolescents from 15 to 19 years of age. Violent deaths in both age groups disproportionately affect black children more than white children except for suicide. /2008/There was a 12.7% decrease in the child death rate in Louisiana from 34.8 in 2002 to 30.4 in 2005, though both rates were higher than the 2002 and 2004 national average of 21.4 and 20.0, respectively. Preliminary 2005 vital records data has unintentional injury followed by congenital anomalies and homicide as leading causes of death in children aged 1-14, and motor vehicle crash deaths accounted for the largest number of unintentional injury deaths, followed by fire and drowning in the same age group.//2008//

According to the 2000 census, Louisiana had the fourth highest percentage of children aged 5 to 15 with a disability (7%) as compared to the national rate of 5.8%. In Census 2002, children aged 5 to 15 were considered to have a disability if one or more of the following long-lasting conditions was reported: sensory disability, physical disability, mental disability or self-care disability. Louisiana disability rates for males and females aged 5 to 15 were 8.8% and 5.1% respectively. In comparison, the disability rates for U.S. males were 7.2% and females 4.3% for the ages 5 to 15 population. In Louisiana, mental disability was reported for 5.5%; sensory, physical and self-care disabilities were reported for 1.3%, 1.3% and 1.1% of the 5 to 15 aged group respectively. Louisiana 5-15 age group's disability rates by race and ethnicity are: 6.6% for White, 7.3% for Black; 8.3% for the combined categories of Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, some other race alone and two or more races; and 6.4% for Hispanic or Latino.

Louisiana has an extremely high percentage of children with special health care needs as compared to other states. According to the SLAITS data, this state has the second highest percentage of CSHCN in the nation (15.9%). This is supported by statistics for the number of children under age 16 receiving federally administered SSI payments. Louisiana is the 11th highest state in the number of children receiving SSI while the 2004 U.S. Census indicates that Louisiana ranks 24th in population. /2007/ In 2005, Louisiana had the 10th highest number of children under age 16 receiving SSI and for 2004, the 3rd highest number of recipients as a percentage of resident population in the U.S.//2007//

For those Louisiana families of CSHCN in the SLAITS survey, 85.5% indicated that their child received SSI, compared to the national survey response of 70.7%. The 2004 SSI data shows that 26,671 children under age 16 in Louisiana received SSI. This is an increase of 3,671 children from the 2001 Louisiana SSI count of 23,000 for this age group. Since persons with disabilities use significantly more medical services than those without disabilities, the high prevalence of disabilities among children in the state, indicates a tremendous need for health care services and resources for children with special health care needs. /2007/ The 2005 SSI data report Louisiana has 24,448 children under age 16 who received payments. This is a decrease of 2,223 from the previous year.//2007// ***/2009/ In 2007, 25,541 children under 16 years received SSI payments, an increase of 4.5% (1,093 children) since 2005. This does not reflect an increase in children with disabilities. //2009//***

c. Access to health care

Louisiana has had one of the highest rates of uninsured population in the nation. According to the American Academy of Pediatrics, estimates of uninsured children in 2003, 15.4 % of Louisiana children through 18 years of age were uninsured, which placed Louisiana with the 5th highest rate of uninsured children. An estimated 77% of the remaining uninsured children were income eligible for Medicaid benefits. /2008/ The 2005 Louisiana Health Insurance Survey's estimates 7.6% of Louisiana children through 18 years of age were uninsured. The American Academy of Pediatrics' estimates in 2005, 9.9 % of Louisiana children through 18 years of age were uninsured, and 52.8% of these uninsured children were Medicaid income eligible.//2008// ***/2009/ The 2007 Louisiana Health Insurance Survey estimated the percentage of uninsured children in the state decreased to 5.4%. //2009//***

Financial accessibility to health care for low income mothers and children has been through the state Medicaid Program. According to the 2002-2003 Fiscal Year Louisiana Medicaid Program Report, 990,544 Louisianans or 22% of Louisiana's population was eligible for Medicaid. Approximately 21% of Louisiana's population received Medicaid services. The percent of Medicaid recipients has increased by 4.2% since the 1999-2000 fiscal year. In State Fiscal Year 2002-2003, 722,430 or 69% of the Medicaid enrollees were under 21 years of age.

The State Medicaid Program has improved financial accessibility to health care for the MCH population through expansion of Medicaid eligibility for children as well as pregnant women. Improved access for children has largely been through the implementation of the State Child Health Insurance Program, LaCHIP. Louisiana's Child Health Insurance Program (LaCHIP) began on November 1, 1998, as a Medicaid expansion with a phase-in of income level eligibility to 200% of Federal Poverty Level (FPL) to age 19 on January 1, 2001. This program has been successful in increasing the numbers of children on Medicaid not just for the LaCHIP expansion but also for regular Medicaid. Since its inception, enrollment numbers have exceeded expectations with an increase of nearly 312,000 children from birth to 19 years of age enrolled in the Medicaid Program. As of March 2005 there were 669,575 Medicaid enrollees under age 19 through Medicaid/LaCHIP. Along with this, the percent of uninsured children in Louisiana has decreased from an estimated 22% in 1997 to 15.4% in 2003. Improved coverage for pregnant women began in January 2003 when income eligibility for pregnant women was increased from 133% to 200% of FPL.

Reasons for the success of LaCHIP include steps to streamline the eligibility process: 1) a simple, one page application form was created for both LaCHIP and Medicaid for children; 2) 12 month continuous eligibility was initiated; 3) the need for a face to face interview was removed and mail in applications are now accepted; and 4) a Central Processing Office was established to handle all child applications for Medicaid/LaCHIP. Medicaid has relied on regional outreach teams of existing Medicaid field staff to spearhead community-based outreach strategies statewide. Other steps taken since the beginning of the program include: 1) streamlining the LaCHIP/Medicaid recertification form, which is sent out to families after 12 months to re-apply for their children; 2) elimination of the three-month wait period after losing private health insurance before families can apply for LaCHIP; and 3) translation of the application form to Spanish and Vietnamese. With the implementation of the EarlySteps program, a new, shared application was developed for Medicaid, LaCHIP, the Office for Citizens with Developmental Disabilities, the CSHS Program and EarlySteps.

In comparison to the national average, Louisiana consistently ranks below other states on most of the National CSHCN Survey (SLAITS) indicators for access to care. Families report that their children and youth with special health care needs have less access to health care, require more time and financial resources than their peers in other states. Because of the high poverty rate in Louisiana and the fact that Louisiana has the second highest percentage of children with special health care needs of any state, financial access to comprehensive health care is a greater need in Louisiana than in most states. According to the CSHCN National Survey (SLAITS) data, only 51.9% of Louisiana CSHCN families said they had adequate public or private insurance to pay for

the services they need, compared with 59.6% nationally. Forty-nine percent of CSHCN families have an income that is less than or equal to 200% of the federal poverty level. Twenty-two percent have Medicaid as their only source of insurance, 28.1% have more than one type of insurance, 41.5% have private insurance, and 8.1% are uninsured. ***/2009/ NSCSHCN data in 2002 and 2006 shows percent LA CSHCN with adequate health insurance increased from 62.0% to 65.5%, above the 62.0% US average. Percent CSHCN families living below 200% FPL decreased from 54.8% to 51.0%. The percent of CSHCN without insurance decreased from 8.1% to 5.1%, however LA remains above the 3.5% US average. For CSHS patients in 2007, 82.8% had Medicaid, 12.7% had private insurance, and 4.2% had no insurance. //2009//***

Pediatric primary and subspecialty care are concentrated in the major urban areas of the state. CSHS Needs Assessment Data indicates that many of the pediatric sub-specialists were concentrated in the New Orleans area (27%) with many reporting that they traveled to more rural areas to provide care. Although the distribution of primary care for CSHCN was relatively equal by pediatricians and family practitioners across the state, only 52% of primary care physicians reported that they accepted Medicaid as compared to 69% of specialists. In addition, when further analyzed as to physicians offering access to CSHCN and CSHCN with Medicaid, data shows that in some rural regions of the state, access is restricted by half or more of the physicians not accepting patients with special needs and Medicaid. The most often reported barrier to care in focus groups of parents conducted in the CSHS Needs Assessment was lack of services or providers in an area. /2007/ Pediatric subspecialty care in Louisiana has experienced major changes following the Katrina/Rita disasters. Physicians at major medical institutions in New Orleans have relocated or left the state. Children's Hospital, New Orleans has opened satellite clinics in 2 other major cities, Baton Rouge and Lafayette, offering specialty services and accepting Medicaid patients.//2007// ***/2009/ Physician emigration continues despite incentives by the Greater New Orleans Health Service Corp to practice in New Orleans. Tulane and LSU Medical Schools have increased recruitment efforts. Shortage of sub-specialists has increased workloads of remaining physicians, perpetuating the cycle. Despite this shortage, NSCSHCN data indicates percent of CSHCN needing a referral who had difficulty getting it decreased from 23.7% in 2002 to 15.8% in 2006. //2009//***

d. Availability of health care

The majority of the state is designated as a medically underserved area or having underserved populations, by the Office of Primary Care and Rural Health. (Map 4). Availability of primary care practitioners poses a significant problem for delivery of health care in the state. As of March 2004, 56 or the State's 64 Parishes are designated a geographic or population group qualifying as a Health Care Professional Shortage Area (HPSA) (Maps 4, 5 and 6) by the Office of Primary Care and Rural Health.

Beginning in August 2001, the State Medicaid Program began a Region-by-Region expansion of its Community Care Program, which had been operating in 20 Parishes in the State. Community Care is a primary care case management program for Medicaid recipients. Through this Program, all Medicaid recipients are linked to a health care provider who serves as the client's primary care health provider as well as their primary care case manager. The primary care case manager is responsible for ensuring that all clients receive EPSDT services although the screenings may be done by another provider. However, maternity patients are exempted from this program and may select any provider. This process was completed in December 2003. This has resulted in an increase in the number of eligible clients who have received services.

The lack of availability of specialists in many areas of the state compounded with the fact that about one third do not take Medicaid means many CSHCN do not have access to specialty care at all. Because of the urban concentration of physicians in the state, access to Primary Care Physicians (PCP) and specialists in more rural areas of the state is extremely difficult for many CSHCN. Physicians who take CSHCN are concentrated around the two medical schools, children's hospitals, and leading medical institutions located in New Orleans and, to a lesser

extent, Shreveport. A greater percent of specialists take Medicaid than PCP's. Of 631 specialists that take CSHCN, 409 or 65% take Medicaid. However, the lack of availability of specialists in many areas compounded with the fact that about one third do not take Medicaid means many CSHCN do not have access to specialty care at all. /2007/ The expansion of a few Medicaid providers in areas outside of New Orleans increases access for CSHCN in some areas. It is uncertain if these services will remain and expand or return to New Orleans as the population returns to that area.//2007//

Thus, budget shortfalls affecting the financing and therefore the system of health services in Louisiana present a challenge to the MCH Program for assuring the delivery of needed MCH services to the poor, predominantly rural, low education, minority MCH population in Louisiana and to our efforts to decrease the mortality and morbidity in this population. The MCH Program has responded to this by the development of initiatives to accommodate these changes. /2007/ The opportunity to increase access in the aftermath of the disasters with an expansion of health care providers who accept Medicaid is being addressed by the CSHS Program. This will also help to reduce disparities in health care for the CSHCN population.//2007// ***/2009/ Medicaid's Community Care has linked many CSHCN with a MH. CSHS continues to provide sub-specialty care in all nine regions, with larger clinics in shortage areas. //2009//***

3. Current OPH Priorities and Initiatives and Title V's Role
Louisiana, as one of the poorest and unhealthiest states in the nation, has the challenge of using its limited resources for the highest priority activities. Prevention services are under-funded as compared to other health care services. The Office of Public Health has defined its mission as follows:
- To promote health through education that emphasizes the importance of individual responsibility for health and wellness.
- To enforce regulations that protect the environment and to investigate health hazards in the community.
- To collect and distribute information vital to informed decision-making on matters related to individual, community, and environmental health.
- To provide leadership for the prevention and control of disease, injury, and disability in the state.
- To assure universal access to essential health services.

Operating within the context of the Office of Public Health and the changing health care environment, the Title V Program maintains its commitment to decreasing mortality and morbidity and assuring access to primary and preventive health care services for Louisiana's maternal and child health population including those with special health care needs.

For the MCH Program, the development of program initiatives has evolved into a process where data is collected, analyzed, and synthesized with knowledge on best practices to determine what would work best in Louisiana's unique environment. Program directors and epidemiologists review birth and death statistics, Pregnancy Risk Assessment Monitoring System (PRAMS) data, Infant and Child Death Review panels' recommendations, Medicaid E.P.S.D.T. reports, and other sources of information to determine the priority of competing factors impacting the health of pregnant women and children. Most data is analyzed by race and parish to determine racial or geographic disparities and trends in health status. Leading causes and associated factors of maternal, infant, and child death are reviewed and interventions are identified and implemented to address these problems. This year, the MCH Program has completed its five-year community-based assets/needs assessment, obtaining input from public health and community leaders from each region in the state. This has lead to determination of the priority needs for the State and the development of an operational plan to address each priority need.

CSHS implemented strategic planning in 2001 by establishing a Long Range Plan Advisory Committee with statewide stake holders including parents, private and public health care providers, elected officials, CSHS medical providers and local staff. The goal of the Long Range process was to improve the CSHS program by providing Medical Home and subspecialty clinical

services by private providers in the community and monitoring, quality assurance and care coordination services to be provided by specialized OPH staff, where feasible. Critical to this process is the CSHS Needs Assessment completed in 2004 and used for the Block Grant and program planning. A statewide conference was held to analyze data for each region and make recommendations for changes in service delivery models. Work continues on recommendations for changes in the CSHS service delivery system for CSHCN to address areas identified in the Needs Assessment and through focus group and stakeholder participation. The provision of care coordination is one of the major goals to increase access to care and provide transition to adult services. ***/2009/ CC continues to be a priority. The current pilot will be expanded in CSHS clinics statewide over two years, first focusing on transition and then all CSHCN. //2009//***

Thus, the Title V Program addresses each aspect of the OPH mission for the maternal and child population, including children with special health care needs, in the following ways:
- Health promotion is a major priority of the Title V Program, and includes public information and media campaigns on parenting, prenatal care, SIDS, and injury prevention. Public health staff provide health education and counseling to 137,000 pregnant women and children each year in individual patient counseling or group sessions.
- Some of the health hazards addressed by the Title V Program include lead poisoning, car safety and other injury prevention, and child care health and safety.
- The Title V Program shares vital statistics information widely as well as information from the Pregnancy Risk Assessment Monitoring System (PRAMS) which began in 1998. The Child Death Review process informs legislators and policymakers on the needs of children and families in the state.
- The Title V staff lead and participate in various task forces related to the health of women and children, including child abuse prevention, perinatal care, childcare health and safety, child death review, oral health, injury prevention, and birth defects. Title V works with professional and advocacy organizations to promote legislation and regulations to protect and promote the health of women and children.
- Through its system of parish health units, contract sites and school-based health centers, Title V is able to provide a statewide safety net of direct health services for women, children, and adolescents who are uninsured or have no access to other health care providers. With the largest number of poor children of any state, Title V resources continue to be dedicated to direct health care services. Children with special health care needs have access to a comprehensive, family-centered, community-based network of pediatric specialists, including physicians, nurses, social workers, and other health care providers throughout the state through the CSHS clinics and community based services.
- "Every Child Deserves a Medical Home" is a priority of the CSHS program. CSHS Central Office and OPH Regional staff have participated in several regional presentations of the AAP program, "Every Child Deserves a Medical Home." This initiative included the formation of regional committees to address the issue of primary and preventive health care of CSHCN within the specified area of the state. Medical Home training has been incorporated into medical school training and as a pilot project funding care coordinators in three physician practices. ***/2009/ CSHS will continue to assist PCP's to meet the NCQA Patient Centered MH Guidelines through residency training, CC and parent advocacy. //2009//***

An attachment is included in this section.

B. Agency Capacity

/2008/ To address the large dislocation of 4,486 physicians in the hurricane Katrina ravaged New Orleans region, the Greater New Orleans Health Services Corps was established. A $15 million grant from the U.S. Department of Health and Human Services will provide financial incentives to primary care physicians and other health providers who commit to work in the New Orleans region for the next 3 years. To address the health care needs of the migrant population who arrived in the New Orleans region to work on the rebuilding effort, prenatal services were covered by Medicaid for non-citizens under Title XXI State Child Health Insurance Program.//2008//

The State Title V Maternal and Child Health Program is housed in the Office of Public Health (OPH), Department of Health and Hospitals (DHH). The mission of DHH is "to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. The Department fulfills its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner." The other agencies under the Department include the Office of Mental Health, Bureau of Health Services Financing (Medicaid), Office for Citizens with Developmental Disabilities, and the Office for Addictive Disorders. The Assistant Secretaries for each of these Offices meet weekly to collaborate and coordinate services for the citizens of Louisiana.

Personal health services and local public health functions are provided by 70 OPH parish health units distributed throughout the state, except in New Orleans and Plaquemines Parish, which have their own independent health departments (See Map 1 of attachment for map of parish health units). OPH has nine Regional Directors who supervise the health units, regional CSHS clinic sites, and regional health staff in their respective regions. The MCH Adolescent School Health Initiative provides funding and technical assistance to 51 contract school-based health centers, and 1 federally funded school-based health center. Infant Mortality Reduction Initiatives have been funded in each region, including a staff person to coordinate and direct Fetal-Infant Mortality Review, needs assessment and strategic planning for the maternal and child population.

Pregnant women and children, ages 0-21, who have no access to prenatal or preventive health care in the private sector, are served in MCH funded clinics whose services are linked with WIC, Family Planning, and Sexually Transmitted Disease services. Program directors at the state level meet regularly to coordinate these programs so the services will be "seamless" at the local level. MCH services are available in every parish in Louisiana. Orleans Parish operates an independent health department and receives support from the Title V Program. MCH provides funding to the New Orleans Health Department for an MCH medical director, a nurse consultant, and an MCH epidemiologist. MCH services are also provided through other medical and social services entities. Plaquemines Parish operates a clinic which provides EPSDT, immunization, and WIC services.

/2007/Hurricane Katrina, this nation's worst natural disaster, has devastated the New Orleans metropolitan area and has severely impacted the capacity of the Office of Public Health (OPH) and the Department of Health and Hospitals (DHH). Hurricane Rita added to the destruction in southwest Louisiana. The Office of Public Health was particularly affected due to the location of its headquarters in New Orleans. A smaller office of OPH is located with DHH and its other Offices in Baton Rouge. Prior to Hurricane Katrina and in the months following, all OPH nurses and physicians carried out their mandated responsibility to manage the special needs shelters located in each region of the state. These shelters care for the sick and medically fragile individuals who have no other resources. During this time, the State Title V Medical and Program Directors were assigned to the state's Emergency Operations Center in Baton Rouge. OPH was dedicating all its capacity to recovery. As shelters closed, parish health unit staff returned to increased demand for public health services. State OPH headquarters staff was unable to return to the New Orleans office as it was severely damaged by the flooding. Alternative work places were developed near New Orleans and in Baton Rouge as staff was required to return to work in mid-October. Fortunately, MCH only lost 2 staff members due to the hurricane. Although many of the MCH staff lost their homes, work continued immediately following the storm via email, telephone, and with weekly teleconferencing provided by the Centers for Disease Control and Prevention. As access to computer files resumed, and contact was made with the MCH contractors and other partner agencies, some sense of normalcy began.

Katrina caused the shutdown of most hospitals and the near-total disruption of the public health and medical infrastructure in the greater New Orleans area. Nine months after the hurricane, most of the hospitals in New Orleans remain closed including Charity Hospital, with 98% of its

patients being without health insurance. As the population of New Orleans decreased to less than half due to 40% of the city being uninhabitable, those remaining relocated to adjoining parishes. Migrant workers and their families have moved into these areas and without any source of health coverage, depend on OPH for public health services including MCH funded prenatal care. Many of the MCH contracts serving the New Orleans area population have been disrupted due to providers not returning post-Katrina. The prenatal care contracts have been moved to parish health unit locations in Metairie and Marrero (Jefferson Parish), both within close proximity to the population in need. The New Orleans Health Department hired an MCH medical director and eliminated the nurse consultant position. MCH-funded prenatal services in Orleans and St. Bernard parishes are expected to restart during this summer. Plaquemines Parish Health Department is providing immunization services, but until the site providing EPSDT and WIC services is rebuilt, residents access those services in Jefferson Parish.//2007//

CSHS provides family-centered, community-based, coordinated care for children with special health care needs and their families, including rehabilitation services for children receiving SSI benefits, through its network of 175 pediatric subspecialty providers and facilities at the regional and local levels. Parents acting as family liaisons enhance the care coordination provided by the CSHS regional team and provide needed support.

CSHS has implemented a Long Range Plan to improve the system of services to CSHCN and their families in Louisiana. The goal of this process is to enhance community-based, private provider Medical Home and subspecialty clinical services. As CSHS strives to facilitate the development of systems of care for families, services are being merged with existing facilities or moved to local sites to complement the already existing service network established by the staff. CSHS has already begun the process of transitioning some clinical services to community private sub-specialists in the New Orleans and Alexandria areas. A pilot is planned for one region of the state to convert staff to care coordination duties and transition children to private providers. CSHS has also been working with the AAP to work with local communities on capacity of primary health care services for CSHCN by facilitating Medical Home trainings statewide. /2007/ The CSHS Long Range Plan has been adjusted to deal with changes that have taken place after the recent disasters. Transition of services to the private sector has had to be increased at a faster rate as some physicians have resigned and left the state. Care coordination will be increased quicker to assist families to transition to the private sector and to adjust to recovery from disasters. The health care system in Louisiana has an opportunity to transition traditional public health care to the private sector and the CSHS plan will complement that movement as it unfolds.//2007//

/2008/ Families and providers continue to relocate post-Katrina, with some returning to New Orleans, some remaining in other parts of the state, and some leaving the state. Imbalances in numbers of providers per population to be served continue to change, making access to healthcare a continuing problem which is accentuated for CSHCN. For these reasons, CSHS continues to provide direct services in all regions of the state, bringing sub-specialists into underserved areas. Physician contracts have decreased from 95 to 72 since Katrina. Initiatives to improve access to care such as care coordination and medical home activities have new urgency. Training for a second pilot in region VI will begin in August, with the goal of statewide care coordination by the end of 2008. Medical home training in the future will focus on in-services for individual pediatric practices with emphasis on available public and private resources in the community for CSHCN.//2008// ***/2009/ A 2nd pilot of the revised CC system is being conducted in region I. CSHS presented data on the effect of a CC in improving family satisfaction and MH criteria at the state's MH Summit. Medicaid is planning to create capitated Service Provider Networks (PSN's) for pediatric providers to create MHs for CSHCN, modeling after Florida beginning in 2010. CSHS' role in the new system is being negotiated. //2009//***

Enrollment in CSHS services have decreased 23% 2000. This is due to decreased numbers of families eligible for services based on static income criteria for the program. Some CSHS

services have been reduced due to difficulty finding physicians to provide community-based services. The CSHS Long Range Plan Needs Assessment identified the capacity of private providers to serve CSHCN statewide and has led to the formation of a plan to address these issues. /2007/ Enrollment continues to decrease slightly through 2005.//2007//

The Hearing, Speech and Vision Program (HSV) also experienced a decline in the number of staff and patients. Private contractors, including the Lions Eye Foundation and other individual private providers, now provide vision screening services. Audiology services are provided by remaining staff and have been reduced by 50% since 2000. Presently, services are those for infants, toddlers and medically indigent children with hearing loss. Regional audiologists have performed regional needs assessments regarding available audiological services. Transition of these services will be incorporated into the CSHS plan. /2007/ Additional loss of staff occurred in the aftermath of the disasters.//2007// ***/2009/ HSV staff is stable at 7 FTE's, including 4 contract staff. Three Audiologists serve 9 regions. A 4th position was denied. In 2007 there were 634 visits for CSHS audiology and speech services and 333 speech and hearing screenings for toddlers. Over 96% of infants were screened at birth for hearing loss and over 780 school staff were trained to provide vision screening to toddlers and school children. //2009//***

Although the number of patients receiving prenatal and preventive child health services is decreasing, enabling and population-based services provided by contract agencies continue to increase. The State Title V Maternal and Child Health (MCH) Program has been able to shift significant resources from the funding of local parish health unit personnel to contract agencies, targeting services and areas of highest need as identified in the latest MCH Needs Assessments and other current maternal and child health data. This shift is due in part to the downsizing of the Office of Public Health parish health unit infrastructure and the new priority setting of parish health unit services to be offered to the public. In the past few years there has been a dramatic increase in Medicaid coverage of the maternal and child population in Louisiana through the Child Health Insurance Program, LaCHIP and LaMOMS (pregnant women coverage), expanding eligibility to 200% of the federal poverty guidelines. This health coverage and the statewide expansion of Community Care, Louisiana's Medicaid Managed Care system using a primary care case manager model has reduced the need for MCH to provide direct medical services in most areas of the state. The high priority services being delivered by the parish health units include WIC, Family Planning, Immunization, Tuberculosis Control, and Sexually Transmitted Diseases Programs. These Programs have greater difficulty finding community providers with whom to contract. MCH funded prenatal services are still provided in parishes without obstetric medical providers.

However, with a high poverty rate and its associated health problems, Louisiana's pregnant women and children continue to fall at the bottom of most studies that rank the states according to their population's health status. MCH is targeting areas of the state with the worst infant mortality problem by providing preventive and primary care services for pregnant women and infants. Contracts with health and social service agencies have been developed and services initiated to improve the health status of this population in cities including Shreveport, Alexandria, Baton Rouge, Lake Charles, Monroe, Lafayette and New Orleans, as well as Terrebonne, Jefferson and St. Tammany Parishes. Services include fetal-infant mortality review (FIMR) including a community advisory committee for needs assessment and strategic planning, prenatal clinical services, outreach, and case management including the evidenced based intervention, Nurse Family Partnership home visiting program. In some of these locations, the contract agency is the Louisiana State University Health Sciences Center (LSUHSC) that administers the services at the nine regional state operated hospitals in the major metropolitan areas of the state. The state hospitals and LSU have a long history of providing services to the low-income population.

In addition, MCH provides supplemental funding in the four Healthy Start Program areas in order to provide comprehensive services for this high-risk population. Six social worker case managers were added to the New Orleans Healthy Start Program last year and a FIMR coordinator has

been hired for the newly funded Lafayette Healthy Start Program. MCH continues to fund a Nurse Family Partnership team of nurses for the Baton Rouge Healthy Start Program and a team of outreach workers for the North Louisiana Healthy Start Program. /2007/ The New Orleans Healthy Start program has been reorganized due to the hurricane devastation, and the contract for the six social workers has been discontinued. Negotiations are underway with New Orleans Healthy Start to restart a FIMR project and case management services.//2007// /2008/ A FIMR coordinator has been hired by the Healthy Start Program in New Orleans, funded by Title V. The March of Dimes funded a mobile health van for prenatal care services in hurricane ravaged areas including New Orleans, Lake Charles, and St. Tammany Parish.//2008//

A contract with the Medical Center of Louisiana in New Orleans has been established to address the finding in the New Orleans' FIMR that 25% of the infant deaths reviewed had maternal substance abuse involved. The perinatal substance abuse prevention/case management project being implemented is based on Ira Chasnoff's model, which utilizes a comprehensive evidenced-based approach. A similar intervention was initiated this year in Monroe through an interagency collaboration between MCH, Office of Addictive Disorders, LSUHSC, and the Office of Mental Health. Louisiana has among the highest rate of low birth weight in the nation. PRAMS analysis showed that smoking and inadequate weight gain in pregnancy were the primary risk factors for low birth weight. MCH addresses gaps in smoking cessation services for perinatal populations through a contract with the Louisiana Public Health Institute, the recipient of the Louisiana Tobacco Tax Fund. This partnership has allowed expansion of the American Cancer Society's Make Yours a Fresh Start Family, a comprehensive smoking cessation program for perinatal populations. MCH contracts with an advertising agency to administer the Partners for Healthy Babies campaign. This is an outreach effort to link women with prenatal care and promote healthy behaviors. The program utilizes multiple partnerships, media messages, a toll-free information and referral hotline and other promotional activities to reach pregnant women and impact the determinants of low birth weight and infant mortality. This year, proper weight gain was one of the primary media messages. /2007/ Due to the closure of the Medical Center of Louisiana, the contract for maternal substance abuse treatment services has been discontinued. A contract has been established between MCH, Louisiana Office of Addictive Disorders, and Ira Chasnoff to build a statewide system of perinatal substance abuse services. The new MCH hotline contractor, American Pregnancy Association, was operational immediately after Katrina and was instrumental in reaching Louisiana evacuees in-state and out-of-state. Radio and television messages in adjoining states and within Louisiana, resulted in 8 times the average number of calls during the months following the storm.//2007// /2008/ Perinatal Substance Abuse services have been added in St. Tammany Parish and Alexandria and enhanced in Monroe.//2008// ***/2009/ The American Cancer Society has phased out Make Yours a Fresh Start Family Program, changing Louisiana Public Health Institute contract to a policy focus on smoking prevention and other MCH issues. Perinatal substance abuse services have been added to New Orleans and Lafayette and cover perinatal depression and domestic violence. //2009//***

Infant death data, PRAMS information, and FIMR studies show SIDS and prone infant sleeping position to be a problem in Louisiana. The MCH Program contracts with Tulane University School of Medicine, Pediatric Pulmonary Section, for the position of Sudden Infant Death Syndrome (SIDS) Medical Director. This partnership has allowed improved MCH Program state capacity to identify, counsel and follow-up with families of SIDS infants and monitor the functioning of the overall program. The MCH Program staff includes a SIDS Program Coordinator who conducts state and community-based education on SIDS risk reduction, including a statewide media campaign. /2007/ Educational materials were distributed to shelters statewide to promote safe sleep environments.//2007//

To improve Louisiana's low breastfeeding rate, MCH has a contract with the Louisiana Maternal and Child Health Coalition to promote The Gift, a program to certify hospitals as breastfeeding-friendly facilities if they comply with a list of breastfeeding related policies and activities. Educational materials and incentives are included in this intervention.

MCH is targeting the leading causes of child morbidity and mortality by providing preventive and primary care services for children. Comprehensive preventive child health services, including physical examinations, laboratory and other screening procedures, immunizations, nutritional assessments and counseling, health education, and WIC services will continue to be provided in parish health units for children whose families are uninsured or are Medicaid eligible and have no access to private care. WIC services, immunizations, psychosocial risk assessment, and health and parenting education will continue to be provided in parish health units to patients referred by other health providers. MCH has a contract with Medicaid to conduct EPSDT screening in parish health units. Although private provider participation has decreased the number of children screened by MCH, there are still areas of the state where access is a problem and EPSDT services in parish health units continue to exist. MCH funds will continue to contract with St. Thomas Health Services, Inc. in New Orleans to provide support to community-based child health programs which provide pediatric primary care.

Through an interagency agreement with the Office of Community Services (Child Protection Agency), MCH utilizes public health nurses to assist child protection workers in investigating suspected cases of medical neglect, malnutrition and failure to thrive. Nurses assess the child in the clinic or home within 24 hours of request.

The state mandated Newborn Screening and Follow-up Program ensures that all newborns are screened before discharge from the hospital and again at the first medical visit, if the baby was initially screened before 48 hours old. The newborn screening battery consists of tests for the detection of Phenylketonuria (PKU), congenital hypothyroidism, hemoglobinopathies (sickle cell disease), biotinidase deficiency, Maple Syrup Urine Disease, homocystinuria, medium chain AcylCoA dehydrogenace deficiency (MCADD), citrullinemia, argininosuccinic aciduria, and galactosemia. For infants with abnormal tests, Genetics Program staff assist the primary medical provider through the follow-up process to ensure timely and appropriate confirmatory testing and if determined to be diseased, treatment. The Genetics Program follows patients for specific time periods depending on their disorder. Contracts with three Louisiana medical schools will continue to provide laboratory testing and specialized clinical services for these patients.

/2008/ The newborn screening panel was expanded in August 2006 to include congenital adrenal hyperplasia, Carnitine uptake defect, Long-chain 3 hydroxyacyl-CoA dehydrogenase deficiency, Trifunctional protein deficiency, Very long-chain acyl-CoA dehydrogenase deficiency, Glutaric academia type I, 3-hydroxy-3-methylglutaryl-CoA lyase deficiency, Isovaleric academia, 3-methylcrotonyl-CoA carboxylase deficiency, methylmalonic academia (CBL A,B), Beta ketothiolase, Methylmalonic academia (MUT), Proprionic academia, Multiple carboxylase deficiency, Tyrosinemia type 1. July 2007 screening for Cystic fibrosis will begin.//2008//

MCH has initiated a new program entitled, Best Start, a therapeutic health/infant mental health intervention, utilizing a nurse, social worker and case manager to provide 8-10 week small group interventions during the prenatal, newborn and toddler periods Rapides, East Baton Rouge, Iberia, Ouachita, and Calcasieu parishes. Limited home visitation and ongoing treatment for mother-infant dyads in need of those services will be available on a limited basis. /2007/ Best Start services have been absorbed by the state mental health agency's Early Childhood Supports and Services program in East Baton Rouge and Ouachita parishes. Services continue in Rapides and Calcasieu parishes.//2007//

/2008/ A HRSA funded Perinatal Depression Grant has resulted in the addition of mental health services in the New Orleans region in conjunction with New Orleans Healthy Start Program and Jefferson Parish Human Services Authority. Mental health services have been identified as a leading need in Post-Katrina New Orleans. The Rapides Parish Best Start Program is not currently functioning due to the inability to recruit a qualified mental health provider.//2008//

MCH also funds nurse home visiting programs that follow the model for first-time mothers of low socio-economic status, entitled Nurse Family Partnership (NFP). Nurse visitors follow program

guidelines that include regular visits to the family starting prior to twenty-eight weeks gestation until the child is 2 years of age. Nurses provide health education, referrals, case management and other support to women during and after their pregnancies, and their baby. Initiated in 1999 in four regions, the program now provides services in all regions of the state, including 18 parishes. Services are delivered in Region I (Jefferson Parish), Region II (Baton Rouge), Region III (Terrebonne and LaFourche parishes), Region IV (Iberia, St. Martin, Lafayette, and Vermilion parishes), Region V (Calcasieu, Beauregard and Allen parishes), Region VI (Rapides parish), Region VII (Caddo Parish), Region VIII (Franklin, Morehouse, Ouachita, and Richland Parishes), and Region IX (St. Tammany Parish). /2008/ Additional parishes now receiving Nurse Family Partnership services include (Region III) Assumption and St. Mary; (Region VI) Acadia, St. Landry, Evangeline; (Region V) Jefferson Davis; (Region VI) Grant; (Region VII) Bossier and DeSoto; (Region VIII) Lincoln and Jackson; (Region IX) Washington.//2008// ***/2009/ Nurse Family Partnership services have been added in: Orleans, St. James, Cameron, Avoyelles, Catahoula, Concordia, Lasalle, Vernon, Winn, Natchitoches, Red River, Sabine, and Webster parishes. //2009//***

MCH funds Louisiana's SAFE KIDS program, a comprehensive injury prevention program that organizes local chapters throughout the state, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, childproofing homes, bicycle helmet use, and sports injury prevention. To implement stronger prevention efforts, the MCH Program has established Regional MCH Injury Prevention Coordinators through contracts with social service agencies. These coordinators work to decrease unintentional injuries in children in each of the nine regions to establish and coordinate a region wide system of childhood injury prevention initiatives targeted at preventing injuries in children focusing on the most common causes of injuries in their areas. These Coordinators provide general child safety education and program development through coordinated efforts of MCH, EMS, Injury Prevention Programs and the local SAFE KIDS Coalitions and Chapters. They also provide support to local Child Death Review Panels.

MCH administers the Child Care Health Consultant Program by training, certifying, and facilitating the work of 170 health professionals who provide consultation and training on health and safety for childcare providers statewide. The Child Care Health Consultant Program trains and certifies consultants who provide the three hours of health and safety training required by Child Care Licensing in the Department of Social Services. Social and emotional health are being incorporated into this program's efforts. /2008/ There are currently 117 certified child care consultants operating in Louisiana.//2008//

MCH will continue to provide supplemental funding to the OPH Family Planning Program, which provides comprehensive medical, educational, nutritional, psychosocial and family planning services to adolescents and adults. MCH funds the Teen Advocacy Program in Baton Rouge, a community-based case management program for pregnant and parenting teens. A Medicaid waiver is being developed to continue coverage of family planning services for women past the current postpartum period and to include reproductive age women up to 200 percent of the Federal Poverty Level. /2007/ The Teen Advocacy Program has been absorbed by the Baton Rouge Healthy Start Program. The Family Planning waiver is expected to be implemented in July 2006.//2007// /2008/ The Family Planning waiver was implemented October 2006. Both Medicaid and the Office of Public Health have hired coordinators for each region to facilitate eligibility and provider outreach.//2008//

MCH funds the Louisiana Adolescent Suicide Prevention Task Force to develop and implement a Louisiana statewide plan on adolescent suicide prevention. MCH contracts with social service agencies to provide training on suicide prevention to school personnel statewide. /2007/ MCH collaborated with the Office of Mental Health on a grant to expand these services statewide.//2007// /2008/ Louisiana was successfully awarded a suicide prevention grant aimed at the hurricane Katrina and Rita impacted areas of Orleans, Jefferson, Plaquemines, St. Bernard, Vermillion, Calcasieu, Cameron and East Baton Rouge parishes. Statewide awareness,

education, training and community mobilization will occur.//2008//

The Adolescent School Health Initiative Program will continue to collaborate with the Department of Education (DOE), the Office of Mental Health (OMH), the Office of Addictive Disorders (OAD) and the Excellence in Health and Education Project (EHEP) at Southeastern Louisiana University. Goals of the collaboration include providing state-of-the-art teaching and learning opportunities, advocating for the health and well-being of individuals in schools and communities, conducting research and evaluating services, and establishing a clearinghouse of resources for coordinated health and education.

CSHS provides rehabilitation services for CSHCN in nine clinic sites statewide, including services to children receiving SSI. CSHS provided services to 5,360 children in 17,088 clinic visits. Although the number of children enrolled has decreased, the number of visits has decreased at a slower rate, indicating the more complex and medically fragile patients remain on the program. /2007/ In FFY 2005, CSHS provided services to 5,236 children in 17,742 visits continuing the trend of decreasing patient population with increased number of visits.//2007// /2008/ In 2006 CSHS provided 16,513 visits, which was a 6.94% decrease from 2005. Increases in Medicaid enrollment allowed some patients to move to the private sector, and some patients moved out of state. The number of new patient visits increased slightly in 2006.//2008// ***/2009/ The number of CSHCN in the state has decreased 19.1% and more CSHCN have Medicaid, however the number of children receiving CSHS services has increased because of CC. CSHCN seen in CSHS clinics in 2008 was 4645 with 17,874 visits. The total served was 11,167, which is an increase of 9.1%. //2009//***

CSHS funds a specialty Dental Clinic for children with special health care needs in the New Orleans area. Services are provided by LSU School of Dentistry (LSUSD) and are specially designed to be readily accessible to this population, known to have barriers to accessing regular dental care. CSHS provides assistance through DHH/OPH Regional Offices for non-Medicaid eligible children to receive routine dental services through the private sector.

The CSHS Program provides parent support through all clinic team members including nurses, social workers, clerical staff, physicians, nutritionists, audiologists, other allied health staff and Parent Liaisons. Parent Liaisons are paid parents of CSHCN who attend clinics to give parent to parent support and organize and participate in support groups for families of CSHCN. In addition, the CSHS Parent Liaison staff work with the CSHS staff in identifying and incorporating culturally appropriate services to the diverse population served in CSHS clinics. Parent Liaison staff have provided community programs on cultural diversity and continue to work with families to identify better ways to improve services to families. All Parent Liaisons have undergone leadership training to increase their capacity to promote independence in families of CSHCN. /2007/ The leadership training for the Parent Liaison staff has resulted in some graduates moving to advocacy leadership positions in the state, increasing the capacity for parent involvement and direction in Louisiana.//2007// /2008/ Parent liaisons continue to be a vital part of each CSHS clinic team. In 2006 13 parents completed the 16 hour parent liaison training.//2008// ***/2009/ CSHS has 12 parent liaisons who received 18 hours of training in 2007. This included 6 hours in QUEST, a curriculum to enable parents to navigate the healthcare system to meet their needs. //2009//***

CSHS care coordination is family-centered and supportive of the child and caregiver needs through a plan that improves the quality of life by providing family support and enhancing family well-being. The inclusion of transition services into care coordination supports the self-determination and independence of adolescents with CSHCN. /2007/ Care Coordination procedures will include a focus on fostering independence in families to navigate the health care and other systems of services as well as become good consumers of services. The Parent Liaison staff will play an integral role in care coordination and provide parent to parent training to encourage independence and stability.//2007//

As of July 1, 2003, DHH became the lead agency for the Part C/Early Intervention System, now called EarlySteps. This system transitioned from the Department of Education, which had been the lead agency since 1986. CSHS works with agencies statewide to build the system capacity to provide quality early intention services for infants and toddlers with developmental disabilities. DHH has established interagency agreements with the Department of Education/Special Populations, Office of Health Services Financing (Medicaid) and Office of Citizens with Developmental Disabilities to provide funding for Part C services. CSHS will also continue to work with other agencies to access additional funding, which will increase the capacity to serve infants and toddlers with developmental disabilities. In the first year of implementation, the number of children identified increased by 43% due to the longstanding emphasis on early identification within the Office of Public Health and the MCH and CSHS programs. A significant indicator of the impact of Part C being managed under a health agency is the dramatic increase in the number of children from birth to one year enrolled. In 2002 331 children under the age of one year were enrolled in Part C, in 2004 that number increased to 2,934, an 89% increase in 2 years. Budget issues with the tremendous increase in the number of children identified have triggered a significant restructuring of the program to make the best use of limited funding. /2007/ The number of children served and expenditures have decreased after recent disasters. In addition, EarlySteps is implementing changes to the system to a more moderate eligibility criteria and to begin family cost participation. Best practices promote family-centered intervention and involvement. The major changes to this system and disaster effects on the population will make the current year a pivotal point in early intervention.//2007//

State legislation in 1999 established the Birth Defects Monitoring Network. Under the CSHS program, data collection started in 4 areas of the state in January 2005. Parents of children identified through the system will be offered information and referral to health care systems, as appropriate to their child's identified birth defect. ***/2009/ The Birth Defects program received state funding in 2008 for two additional staff, permitting coverage of over 70% of births and mailing of resource guides to families as of later this year. //2009//***

The Early Hearing Detection and Intervention (EHDI Program), within the Hearing, Speech and Vision Program, works closely will all birthing hospitals in the state to ensure hearing screening for all newborns. Newborn hearing screening results are reported on the electronic birth certificate. The EHDI program matches initial hospital hearing screening and follow-up results and is able to identify infants that have not had a screening test. Follow-up is provided for all infants with an abnormal newborn hearing screening, as well as infants that have not had a screening test. EHDI staff provided training and technical support to hospital personnel and also work with private providers to facilitate follow-up hearing evaluations. /2007/ Newborn Hearing Screening and Birth Defects have had to adjust to shifting birth populations after the disasters. Birthing services continue to change as the health care system in the state adjusts. A recent announcement of discontinued birthing services at a major public hospital in Baton Rouge is an example of significant shifts in service delivery and surveillance.//2007//

CSHS funds a clinic at University Hospital in New Orleans to provide developmental services to children of mothers who are substance abusers. In addition to assessments, families are assisted with information, referral and follow-up to programs and agencies as determined by the needs of the child and family.

CSHS funds a program for specialized care of children with diabetes at Children's Hospital in New Orleans. This goal of this multidisciplinary program is to reduce emergency room visits, improve growth and development of the children, as well as decrease the average blood glucose level of the enrolled children. ***/2009/ This program demonstrated a decrease in children's Hgb A1c levels with increased staffing provided by CSHS funding. //2009//***

The Louisiana Medical Home project under CSHS has participated in the National Medical Home Learning Collaborative. It currently funds a care coordinator in 3 pediatric practices in the state. In addition, training of medical school residents has been incorporated through the CSHS Medical

Director who is on faculty at LSU Medical School. ***/2009/ All pediatric residents in LSU and Tulane Medical Schools are trained in MH. CSHS provides CC's for two pediatric practices with plans for expansion. //2009//***

/2009/ The MCH and CHSCN Programs disseminate data on racial and ethnic sub-populations to state, regional, and local public health leaders in order to inform program development, including the regional Fetal Infant Mortality Review's (FIMR) 9 Case Review Teams and Community Action Teams. Latino Health Access Network (LHAN) in the New Orleans region conducted a "secret shopper" survey of OPH Parish Health Units and reported the findings to MCH who provided this information to OPH administrative leadership. One of the bi-monthly trainings for MCH and CSHCN staff addressed cultural competency and the content was incorporated into the MCH new hire orientation process. Training on cultural competency for MCH central office, local field staff and contractors was provided by the Tulane University MCH Leadership grant program, Michael Lu, M.D. (focused on the effects of maternal stress and racism), and MCH's Infant Mental Health trainers. MCH toll free information services and related public relations campaign and Perinatal Substance Abuse program provide Spanish language materials and both use Spanish speaking translators. FIMR and SIDS initiatives include faith-based components. MCH Oral Health Program works with the minority dental society and African American churches Louisiana's to reduce Louisiana's racial disparities in health status. //2009//

The following State statutes are relevant to the Title V program:
1. LSA-R.S. 46:971-973 - Administration of MCH Services in State of Louisiana - Health Department Responsible
2. LSA-R.S. 17:2111-2112 - Vision and hearing screening - Health Department and Department of Education Responsible
3. LSA-R.S. 33:1563 - SIDS autopsy; reporting to Health Department Required
4. LSA-R.S. 40:1299 - Mandated Genetics - Newborn screening - Health Department Responsible
5. LSA-R.S. 40:1299.111-.120 - Children's Special Health Services - Health Department Responsible
6. LSA-R.S. 40:5 - State Board of Health authority to create MCH & CC Agency
7. LSA-R.S. 40:31.3 - Adolescent School Health - School Based Clinics - Health Department Responsible
8. LSA-R.S. 46:2261 - The Identification of Hearing Impairment in Infants Law - Health Department Responsible
9. LSA-R.S. 40:31.41-.48 -- The Births Defects Monitoring Network - Health Department Responsible

An attachment is included in this section.

C. Organizational Structure

The Department of Health and Hospitals is one of twenty departments under the direct control of the Governor. The State Health Agency, the Office of Public Health is one of the five major agencies within the Department of Health and Hospitals (DHH). The State Medicaid Agency, Bureau of Health Services Financing, is also located in this Department as well as the Office of Mental Health, Office of Addictive Disorders and the Office for Citizens with Developmental Disabilities. The Title V programs, the Maternal and Child Health Program and Children's Special Health Services, are located in the Center for Preventive Health in the Office of Public Health, along with Family Planning, Nutrition, Genetics, Tuberculosis Control, Immunization, Sexually Transmitted Diseases and HIV/AIDS, and Adolescent and School Health Programs. The organizational charts in Figure 1 of the attachment illustrate the structure of the departments under the Governor, DHH, Office of Public Health, Center for Preventive Health, MCH, and CSHS.

The Children's Cabinet in the Office of the Governor provides a monthly forum for the Secretaries

of the child serving departments to meet and address the needs of children in Louisiana. The Children's Cabinet Advisory Board consists of the Assistant Secretaries of the agencies within the departments that serve children, as well as non-profit and advocacy organizations. This Board meets monthly and makes recommendations for policy, program development, and funding for child issues. MCH is represented on subcommittees of the Board. The Early Childhood Comprehensive Systems grant is being administered as a joint project of the Children's Cabinet and the MCH Program. ***/2009/ The Genetics Program is responsible for the proper administration of the Title V funds allocated to this program and provides annual reports and plans related to their particular performance measures. //2009//***

The Office of Public Health is organized into five centers, Center for Preventive Health; Center for Environmental Health; Center for Health Policy, Information, and Promotion; Center for Administrative and Technical Support; and Center for Community Health. The Center Directors, Program Directors, and Regional Directors meet regularly. The MCH and CHSCN Program and Medical Directors are the individuals primarily responsible for administering the programs funded by Title V. These staff report to the Director of the Center for Preventive Health, who in turn reports to the Assistant Secretary of OPH. The Directors of the Family Planning, Immunization, and Adolescent and School Health Programs are responsible for the proper administration of the Title V funds allocated to these programs and provide to the Title V Director annual reports and plans related to their particular performance measures. /2008/The Office of Public Health is organized into six centers, Center for Preventive Health; Center for Environmental Health; Center for Health Policy and Information; Center for Administrative and Technical Support; Center for Community Preparedness and Center for Community Health.//2008//

MCH conducted an internal assessment of its organizational structure during last fiscal year. Fifteen lead MCH staff members attended a 4-day assessment and planning process, facilitated by a local consultant. Needs identified included new positions, staff recruiting, orientation, and retention, mentoring programs for new staff, communication and collaboration, contract development and monitoring, and physical space. A strategic plan was developed and subcommittees were formed to address each of these areas. As a result, a new orientation process was implemented for all new staff including a manual; a mentoring program was developed; new positions and vacancies were all filled; a contract manual and training module was presented to all MCH staff; a physical space plan was developed and most of the changes have been put in place. To address the communication/collaboration needs the MCH Program was re-structured by population and functional areas including Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, Health Education, and Mental Health. The Team Leaders for Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, and Mental Health meet with the MCH Director and assistant MCH Director every other week for a MCH Management Team meeting to foster collaboration among these programmatic and functional areas and to keep the MCH Director and each other informed. The Team Leader for Health Education meets with the health education team once a month and with the MCH Director once a month. The Maternal Health, Child Health, and Nurse Family Partnership Teams meet separately once a month and the Epidemiology Team meets weekly. MCH began a monthly series of meetings under the banner of "MCH Issues and Approaches." MCH staff and MCH stakeholders are invited to hear a focused presentation on an MCH topic, followed by a question and answer session. Over 200 people attended these meetings in the last year. An MCH Office Operations and Communications Committee meets bi-monthly to discuss any issues with the building or work environment that need addressing. The CSHS staff has undergone a rapid expansion with the addition of the Part C program, EarlySteps, and new staff dedicated to early interventions. CSHS staff meets monthly and individual work units, such as EarlySteps, Hearing Speech and Vision, and Birth Defects meet as needed. The CSHS administrative team of Program Manager, Medical Director, Nurse Consultant, Social Work Consultant and Parent Consultant meet frequently about policy issues and to approve special requests for services. The CSHS Management Team makes periodic visits to regional clinic sites to offer technical assistance and to gain input for program planning. CSHS and MCH collaborate through the MCH Epidemiology section where technical assistance is provided to the CSHS Epidemiologist and the Birth Defects Monitoring

Network Coordinator. /2007/After Hurricane Katrina Office of Public Health staff from the affected area were dispersed throughout the state and across many states. The subsequent reorganization of office space including locating space for critical staff and re-establishing communication systems has been difficult and continues. A governor's freeze on travel restricted program operations and hindered progress on program goals. CSHS Central Office staff have had as many as 4 temporary office locations and are still waiting for more permanent housing. This has required changes in the way office team members communicate and work together.//2007//

/2008/The Oral Health Director is part of the MCH Team Leadership and was successful at obtaining an infrastructure grant from HRSA that will add two central office management and evaluation staff.//2008//

/2008/ The CSHS staff has undergone a reorganization with the departure of the CSHS director/ program manager. The CSHS staff was organized into four programs with a CSHS Medical Director overseeing the four. The programs were CSHS, Hearing Speech and Vision (HSV), Birth Defects, and Early Steps (Part C program). The Early Steps program was moved to OCDD as of July 1, 2007. The three program directors meet frequently with the medical director about the overall direction of the programs and how to integrate services of the three programs for families. Central to this concept is developing integrated data systems. The CSHS Management Team of Program Manager, Medical Director, Nurse Consultant, Social Work Consultant and Parent Consultant make periodic visits to regional clinic sites to offer technical assistance and to gain input for program planning. CSHS and MCH collaborate through the MCH Epidemiology section where technical assistance is provided to the CSHS and HSV Epidemiologists and the Birth Defects Monitoring Network program manager. Vacancies in the social work consultant position and the CSHS program manager position from September of 2006 until August 2007 resulting from worker shortages made it difficult to start new initiatives in post-Katrina New Orleans. These have now been filled and/or posted at higher levels, and a new position has been approved for the Birth Defects program to assist with statewide expansion of the program.//2008// ***/2009/ CSHS structure remains unchanged with program managers for the CSHS program, the Hearing Speech and Vision program and La Birth Defects Monitoring Network (LBDMN) reporting to the Title V CSHS Director. Of the 10 vacancies in the program post Katrina, 9 were filled before a hiring freeze was instituted in 2008. Two new positions were added for LBDMN using new state funding, including a Family Resource Coordinator and an additional data collection specialist. These will permit this program to cover approximately 70% of births and meet the legislative mandate to provide resource materials to families in the registry. Requests for a fourth audiologist for the HSV program for regions I and III and a social worker for region V for the CSHS program were denied when OPH positions were recently cut by the new administration. Staff shortages in the regions has resulted in staff increasingly being pulled for duties in other programs, leaving few staff dedicated to CSHS clinics and care coordination activities. //2009//***

The Nurse Family Partnership (NFP) team meets quarterly with the supervisors of the OPH and contract sites and conducts annual training with all NFP nurses. ***/2009/ The Nurse Family Partnership Program received additional funding in fiscal year 2009 from the Department of Social Services, Temporary Assistance For Needy Families Program and added 32 nurse home visitors. Two quality improvement nurses were hired to provide training, technical assistance, monitoring, and evaluation. //2009//*** State MCH staff spends a great deal of time providing consultation and technical assistance with other public agencies, contract agencies, advisory boards and commissions.

The state is divided into nine administrative regions (see Map 1), with OPH Regional Directors in each of the regions responsible for identifying and addressing the health needs of the population, assuring the quality of care, and providing monitoring and reporting of MCH services delivered through parish health units and contracts. State MCH Medical Directors and Nurse Consultants are responsible for the quality of the clinical services funded by MCH. Each contract funded by

MCH has an MCH staff member responsible for ongoing performance monitoring. Program and contract monitoring consists of monthly review of fiscal information and performance indicators; and quarterly to annual on-site meetings with contract agencies to determine the quality of the service. Training and technical assistance is provided on a regular basis by MCH staff.

Health status information is shared with state, regional, and local public and private health and community leaders in an effort to engage stakeholders to partner with MCH to improve the maternal, infant, child, and adolescent morbidity and mortality rates. State MCH staff provides technical assistance and consultation to help local stakeholders in assessing needs and developing plans to address the needs. MCH provides funding to local entities or assists these groups in obtaining other sources of funding to address their maternal and child health needs. In order to strengthen MCH infrastructure in each of Louisiana's 9 regions, MCH has established regional Infant Mortality Reduction Initiatives, including contracts for the hiring of a coordinator for each region. The Initiative includes Fetal-Infant Mortality Review, needs assessment, strategic planning, and advocacy for the maternal and child population.

An attachment is included in this section.

D. Other MCH Capacity

In addition to the Regional Administrator, each region has a Medical Director, Regional Nurse Consultant, Administrative Manager, Social Worker, Nutritionist, and Regional CSHS Staff. Although policy development and programmatic direction are provided by the State MCH Program staff, regional and local staff provide significant input. The State MCH/CSHS Program staff includes a Maternity Program Medical Director, Child Health Medical Director, MCH Program - Title V Director, CSHS Program Director and CSHS Medical Director. Staffing also includes a Statewide Maternity Nursing Consultant, Pediatric Nursing Consultant, CSHS Nursing Consultant, CSHS Social Work Consultant, CSHS Statewide Parent Coordinator, CSHS Statewide Part C Early Intervention Program Manager and Parent Consultant, Hearing, Speech, and Vision Program Director, Newborn Hearing Screening Statewide Parent Coordinator, MCH Assistant Administrator, MCH Nutritionist, SIDS Program Coordinator, Mental Health Coordinator, two CSHS accounting and contract monitoring staff, an Oral Health Director, a part-time Dental Consultant and Fluoridation Coordinator, three PRAMS staff, a Birth Defects Registry Coordinator, a CDC assignee MCH epidemiologist, MCH Health Education Coordinator, MCH Health Educator, Nurse Family Partnership (NFP) Director, NFP Nursing Consultant and NFP Program Manager, Child Death Review Nurse, Adolescent Health Initiative Coordinator, Folic Acid Coordinator, Adolescent Health Medical Director, four Adolescent and School Health staff, and ten clerical staff. Through MCH and CDC grants, The MCH Epidemiology Program also includes a CSHS epidemiologist, an Epidemiologist Coordinator for the Newborn Hearing Screening program, two Systems Development Initiative Epidemiologists, two CDC fellows, and an MCH Epidemiologist for the City of New Orleans Health Department. /2007/ Changes to the staffing in MCH include a decrease in PRAMS to 2 epidemiologists and no current Folic Acid Coordinator. The MCH Epidemiologist for the City of New Orleans has expanded to a statewide focus, assuming the responsibilities of the CDC assignee MCH epidemiologist. A statewide freeze on hiring was enacted after the disasters in Louisiana. CSHS had a vacant Epidemiologist position and has since lost several vital contract staff. Hearing, Speech and Vision lost several contract staff including the Newborn Hearing Epidemiologist. The freeze is expected to be lifted July 1, 2006 and recruitment has been initiated in anticipation of replacing positions as soon as possible in July.//2007//

/2008/ A grant is being submitted to reestablish the Folic Acid program. There is currently one CDC fellow and an epidemiologist-evaluator funded by the Perinatal Depression grant. The Child Death Review nurse responsibilities have been assumed by the Pediatric Nursing Consultant. A Program Manager and a Program Monitor are in the process of being hired for the Oral Health Program, funded by a HRSA grant.//2008//

/2009/ The Oral Health Program Manager and Program Monitor were hired in June 2008. The part time fluoridation coordinator has been replaced by the full time Program Manager. The CDC fellowship expired and there is currently no CDC fellow in MCH. Adolescent and School Health Program has an evaluation/data manager. The MCH Health Education team has been reorganized and has added a Child Safety Coordinator whose duties include Child Death Review and Injury Prevention. The SIDS Risk Reduction Coordinator's responsibilities include the MCH parenting newsletter and other MCH health education materials for the public. An additional nurse consultant has been hired to provide training, technical assistance, and monitoring for the new Nurse Family Partnership programs added in the northwest and central regions. //2009//

/2008/ When Linda Pippins, CSHS Director, retired in September 2007, Dr. Susan Berry, CSHS Medical Director, took her position. This resulted in a reorganization of CSHS with program directors for each of the four CSHS programs reporting to Dr. Berry. This, combined with vacancies created by loss of staff post-Katrina, left many key positions vacant for several months, including the CSHS program director, the CSHS social worker, and a program monitor position responsible for helping with contracts. In recent months much progress has been made in filling these positions: the contract monitor is moving into the CSHS program director position, two epidemiologist positions and the program monitor position have been filled. The contract monitor position will be posted in August 2007. A new position has been approved for birth defects monitoring. Filling these key positions is essential for continued progress on initiatives such as care coordination and medical home.//2008//
/2009/ All vacancies have been filled except for one program monitor position, which has since been cut. The CSHS social worker hired in late 2007 has taken the lead with care coordination in CSHS clinics. Two additional positions were added for La Birth Defects Monitoring Network (LBDMN) utilizing new funding. This has permitted this program to fulfill more of its legislated mandate by increasing the percent of births captured in the surveillance system to 70% and providing families in the network with resource materials. //2009//

In addition to program consultation, the CSHS Medical Director will work on special projects, such as Medical Home for CSHCN. One of the Medical Home priorities is to work with the Medical Home Learning Collaborative grant, which will enhance the capacity of Medical Home practices in the state. Medical Home training is being incorporated into the training of medical residents at state medical schools. A medical home project coordinator and social work consultant are also under contract to enhance primary core services through the Medical Home Project. /2007/ The Medical Director has taken a leadership role in the CSHS Long Range Plan in conjunction with the changes to the state health systems after the disasters. The Medical Home Project coordinator and social work consultant have also left and those contract positions will be reevaluated.//2007// /2008/ The Medical Director has continued to lead the Medical Home Initiative and the social worker position should be filled shortly.//2008//

Early Steps, the Part C Early Intervention system, has 16 positions, including Program Manager. Seven of these positions are in Central Office and 9 positions are in the field, with one Regional Coordinator in each of the nine OPH regions. Some CSHS and EarlySteps staff work across programs to make the most efficient use of time and effective use of expertise. Parent Community Outreach specialists are also employed in each region as well as a full time Parent Consultant for Early Steps. /2007/EarlySteps has also experienced several vacancies due to staff resigning after relocations and changing jobs after Katrina. These positions are in the process of being replaced.//2007//
/2008/ Early Steps will move to the Office for Citizens with Developmental Disabilities (OCDD), which is under DHH but not under OPH, as of July 1, 2007. This will mean a transfer of 18 positions statewide, of which only 4 are in central office. These positions were dedicated to Early Steps, and their loss will not detract from CSHS activities.//2008//

The number of OPH Parish Health Unit staff resources (FTEs) funded by the MCH and CSHS

Programs is approximately 77 and 46 respectively. As the number of staff decreases in the direct health care portions of the program, staff is being hired through contracts to initiate nurse home visiting programs and other initiatives across the state. Contracts are now in place to begin to build MCH services in areas of greatest need through contract agencies and institutions including medical schools, state operated and other hospitals, regional health and human service entities, and non-profit social service agencies. /2007/ The number of Parish Health Units FTEs funded by MCH and CSHS Programs is approximately 63 and 46 respectively. //2007//
/2008/ The number of Parish Health Units FTEs funded by MCH and CSHS Programs is approximately 61 and 43 respectively.//2008// ***/2009/ The number of Parish Health Units FTEs funded by the MCH Program is approximately 38, plus 40 Nurse Family Partnership home visiting nurses hired by OPH. The number of regional staff that code time to CSHS is 65, however these are not all FTE's. CSHS also contracts for 12 parent liaison, an epidemiologist and follow-up coordinator for EHDI, 3.5 data collections specialists for LBDMN, a care coordinator (CC) for a pediatric practice, and pediatric sub-specialists for its clinics. A second CC for the LSU faculty practice medical home, who was slated to train CC's for other practices, has left the state. CSHS is interviewing for this position and has initiated a contract for a CC supervisor to be hired through a contract with LSU. Requests for an audiologist for Regions I and III for HSV and a social worker for Region V to assist with CC in CSHS clinics were denied during recent position cuts to OPH. //2009//***

/2008/ A CSHS nurse and staff training will be held in September 2007. This training will cover not only CSHS skills and CSHS emergency preparedness training, but also policies and procedures for the new Care Coordination Initiative.//2008// ***/2009/ The CSHS nurses training was held in conjunction with the first CSHS annual conference since Katrina. These were attended by 14 nurses and 85 CSHS staff respectively, and focused on Care Coordination and Transition services. The 2008 CSHS nurses training is scheduled for July 2008. An annual conference is scheduled for October 2008 in Lafayette. //2009//***

Previously dedicated CSHS field staff had been integrated into the health units and cross-trained with other programs so that they can perform multiple duties. Additional health unit staff had been trained to assist in CSHS clinics. The CSHS program has provided two weeklong trainings and one clinical training for nurses to foster quality services for CSHCN. /2007/ The training for nurses in special needs issues benefited the agency when Special Needs Shelters were opened around the state.//2007//

Please refer to the attachment for brief biographies of the MCH Senior Level Management Team (Table 1). As of October 1, 2005, the current Child Health Medical Director, Dr. Jean Takenaka will be retiring. Dr. Gina Lagarde has been hired for this position as of July 1, 2005. Dr. Lagarde has 15 years of experience in pediatrics including one as the Director of MCH services for the New Orleans Health Department and a Masters in Business Administration. The double encumbrance period will allow a period of transitional training for Dr. Lagarde.

CSHS employs parents as Family Liaisons in all 9 Regional Offices. In addition to providing one to one family support and information, the Family Liaisons promote the issues critical to families with children with special needs in local communities and at a state level. The CSHS Statewide Parent Coordinator has been instrumental in providing input to policy and establishing links with other consumer organizations at the state and national level. In addition, a position has been established for a CSHS Statewide Parent Training Coordinator to provide consistent training for and communication among CSHS Parent Liaisons.

Nine Parent Community Outreach Specialists were added in 2003 to work in the EarlySteps Early Intervention System. These parents have gone through extensive training and will work closely with the EarlySteps OPH Regional Coordinator. A Statewide Parent Consultant has also been hired to coordinate the services of the Regional EarlySteps parents and to collaborate on policy development. /2007/ The EarlySteps Parent consultant was integral in the development of new policy that affected family cost participation.//2007// /2008/ Parent liaison training is ongoing to

provide parent liaisons for CSHS Subspecialty Clinic and Care Coordination activities.//2008// ***/2009/ Parent liaisons received 18 hours of training in 2007 and have received 12 to date in 2008. //2009//***

To enhance MCH capacity at the regional and urban areas in order to address priority needs, staff have been added through contract agencies. Contracts have been used because there is a strict limit on the number of state employees that can be hired in the DHH agencies. In order to address injury prevention, the leading cause of child death, Injury Prevention Coordinators have been hired in each of the nine regions of the state. These staff work under the direction of the Regional Medical Director. Likewise, to address areas of high infant mortality, Infant Mortality Reduction Initiative (IMRI) coordinators have been hired in all regions of the state. Those hired as coordinators are either obstetricians or nurses. The Regional Medical Directors play a lead role in collaboration with the IMRI coordinators to conduct Fetal-Infant Mortality Review, needs assessment, and strategic planning to address infant death, prenatal care, SIDS, and the interventions to address these problems. In the four Healthy Start projects, MCH has supplemented those programs with funding for prenatal care, or for enabling services such as outreach and case management, or infrastructure.

/2008/ In addition to the Nurse Family Partnership (NFP) staff funded by MCH for the Healthy Start Programs in New Orleans, Baton Rouge, and Lafayette, 4 outreach workers are funded by MCH for the Healthy Start Program in North Louisiana parishes. In addition to the OPH staff working in NFP, another 50 nurse positions are hired through contracts. Contracts for prenatal providers and support staff in areas with access problems fund approximately 8 full time equivalents (FTEs). A part time pediatrician is hired under contract to provide services to low income children in a primary care center. Approximately 4 social workers are hired through social service agencies to address maternal and infant mental health issues. Contracts with universities, social service agencies, and Louisiana's Public Health Institute, add 5 FTEs to address perinatal smoking cessation, breastfeeding promotion, local and state MCH systems development, SIDS case review, and infant mental health training.//2008//

In the past year or more, there has been some transitioning of WIC services at the parish health unit away from the traditional use of nurses toward increased use of health educators. MCH is working with the OPH Regional Administrators to identify opportunities to utilize the resulting time available from the nurses who will no longer work in WIC services. The MCH services that nurses will devote their time to includes psycho-social risk assessment of pregnant women and infants and referral of those at risk to social workers, case managers, or other agencies such as the Office of Mental Health or Office of Addictive Disorders.

The MCH Management Team consists of the Maternity and Child Health Medical Directors and Nurse Coordinators, MCH Program Director, Assistant MCH Administrator, MCH Medical Epidemiologist, Mental Health Coordinator, and Nurse Family Partnership Director. Policy and program direction are developed in Management Team meetings held twice a month. The 2005 MCH Needs Assessment was led by the members of the Management Team and this group, along with the Needs Assessment Coordinator and a consultant, are using the Needs Assessment results to create a strategic plan for the next five years and an operational plan for the next 1-2 years. /2007/ The Oral Health Director is a member of the MCH Management Team. The strategic and operational plan for MCH has been completed and monitoring of the plan occurs during the Management Team meetings.//2007//

An attachment is included in this section.

E. State Agency Coordination

/2007/ Hurricane Katrina amplified the need for strong coordination among governmental and non-governmental agencies. State MCH Maternal Health staff worked closely with Family Road (Baton Rouge Health Start agency) who took the lead in coordinating the MCH service providers

in the Baton Rouge area, whose population doubled due to the hurricane. Provider representatives included hospitals, clinics, local health department, March of Dimes, and the agencies established to assist families displaced by the hurricane such as the Louisiana Family Recovery Corps (LFRC). Brochures on prenatal/postnatal health, provider surveys, and other public information was distributed to each of the 9 regional Infant Mortality Reduction Initiatives who in turn disseminated this information to the broader provider and consumer community via their Community Action Teams. The Alexandria and Baton Rouge Initiatives received national recognition for their assistance to displaced pregnant women and their families. The MCH Mental Health Coordinator distributed materials and provided training on maternal depression and children's mental health in response to disasters to mental health providers in Baton Rouge and in the hurricane affected areas including LFRC, Family Road, Office of Public Health, Mississippi National Guard, Office of Mental Health, Nurse Family Partnership and coordinated New Orleans children's mental health provider agencies including Institute of Mental Hygiene, Office of Mental Health, Children's Bureau, Family Services, Volunteers of America, Associated Catholic Charities and the LFRC and the crisis counseling and service organization, Louisiana Spirit. To improve emergency preparedness for the maternal and child population, MCH has collaborated with the Department of Health and Hospitals Office of Emergency Preparedness to develop a state plan. Coordination with the State Commission on Perinatal Care and the Louisiana Chapter of the American Academy of Pediatrics to develop this plan is underway, addressing sheltering of prenatal and postnatal women and their families, inpatient obstetric and neonatal care, and obstetric and pediatric manpower.//2007//

The Maternal and Child Health (MCH) Program has a long history of extensive coordination with public and private agencies and organizations serving pregnant women and children. MCH involvement with the Louisiana's Children's Cabinet Advisory Committee has facilitated the Cabinet's focus on prevention. Established by the legislature in 1998 as a policy office within the Office of the Governor, the Children's Cabinet has as its primary purpose the coordination of policy, planning, and budgeting that affects programs and services for children and their families and the elimination of duplication of services where appropriate. It is composed of the Secretaries of the Departments of Social Services (DSS), Health and Hospitals, Public Safety and Corrections, and Labor; the Superintendent of Education; the Commissioner of Administration; a member of the Louisiana Council of Juvenile and Family Court Judges, and a representative of the Office of the Governor, and a representative of the Children's Cabinet Advisory Board. The Advisory Board provides information and recommendations from the perspective of advocacy groups, service providers, and parents. Advisory Board members represent a wide variety of non-profit agencies, health and educational institutions, assistant secretaries from the Departments listed above, and juvenile court. The Children's Cabinet has recommended maternal and child health interventions among its top 5 priorities for funding, including expansion of the Nurse Family Partnership Program (NFP) (MCH's nurse home visiting program) and MCH administered adolescent school based health clinics. The Early Childhood Comprehensive System (ECCS) grant is administered as a joint venture between the Children's Cabinet and MCH/Office of Public Health (OPH). In the 2004 Legislative session H.C.R. No. 155 was passed asking for cooperation of State Agencies in the development of the strategic plan for the Early Comprehensive Systems Building Initiative. H.C.R. No. 155 "urges and request the following agencies, departments, and their corresponding offices work together in the ECCS strategic planning process: Office of Family Support and Office of Community Services within the DSS; OPH including the Part C - Early Steps Program, Office of Mental Health, Office of Citizens with Developmental Disabilities, Office of Addictive Disorders, and the Bureau of Health Services Financing (Medicaid) within the Department of Health and Hospitals; State Department of Education (DOE) including the Pre-K and Early Childhood Education Programs section; Board of Elementary and Secondary Education; Division of Administration; and Office of Youth Development within the Department of Public Safety and Corrections." The Resolution also called for quarterly reports to the Children's Cabinet and a competed Strategic Plan by June 30, 2005.

Early in the implementation of the NFP Program it became clear that the mental health needs of these first-time, poor, and often young, mothers were significant. MCH requested assistance from

the state Office of Mental Health (OMH). The partnership resulted in the development of infant mental health consultation for these teams. A memorandum of agreement outlines how both agencies will coordinate services across the state. Following the successful implementation of this infant mental health intervention, the OMH received funding for an intervention to identify and mitigate the risks for young children ages 0-5 who are exposed to risk factors such as abuse, neglect, exposure to violence, parental mental illness, parental substance abuse, poverty, and developmental disabilities. The program promotes collaboration and partnership with all entities at the local (parish) level.

The MCH Program has supported an interagency agreement with the Child Protection Agency for the past 11 years to provide public health nursing assessments for children under investigation by the Office of Community Services (OCS) for suspected failure to thrive, malnutrition, or other medical neglect. ***/2009/ The state Office of Mental Health in the New Orleans region and MCH have memorandum of agreement to provide mental health staff to the MCH Perinatal Depression program. The state Department of Social Services, Office of Family Services began providing Temporary Assistance For Needy Families funding to MCH to expand the Nurse Family Partnership Program in October 2008. //2009//***

The Fluoridation Program was created to promote, maintain, and monitor community water fluoridation to reduce the incidence of dental caries in all populations. The Fluoridation Program works with local government agencies to provide education and fund water systems that are initiating community water fluoridation. The Fluoridation Program works closely with the Louisiana Rural Water Association (LRWA) to educate water operators on the benefits and technical aspects of community water fluoridation. Members of the Fluoridation Advisory Board include a practicing dentist from each of the 9 Department of Health and Hospitals (DHH) regions, and representatives from the Maternal and Child Health Coalition, Louisiana Medical Society, Louisiana State University Health Sciences Center (LSU-HSC), Louisiana Rural Water Association, and a state licensed dental hygienist. At the 2004 Oral Health Summit, sponsored by the Oral Health Program, a wide range of attendees were present.

MCH has contracts with a New Orleans non-profit counseling agency to provide mental health services for children exposed to extreme violence including murder, families with a loss due to Sudden Infant Death Syndrome, and at-risk families with children age 0-5.

The Child Death Review Panel, established by the State Legislature in 1993, reviews all unexpected deaths in children under the age of 15. This panel includes representatives from MCH, OCS-Child Protection Agency, Coroners Association, Attorney General's Office, American Academy of Pediatrics, State Medical Society, Vital Registrar, State Police, Fire Marshall, the Legislature and the general public. The MCH Program currently staffs a full time position for the Child Death Review Panel.

The DSS, Child Care Assistance Program is a key partner with the MCH Program's Child Care Health Consultant (CCHC) initiative. The CCHC Program Director serves as a member of the ECCS Strategic Planning Committee, the Louisiana National Infant and Toddler Child Care Initiative, and the Bureau of Licensure's Task Force to write Standards for Quality Child Care. The CCHC Program Director also is chairperson of the CCHC Quality Improvement Committee and the Statewide Interagency Advisory Board for the CCHC Program. /2008/ A child-care quality rating system is being implemented in Louisiana.//2008//

The Medicaid Agency, the Bureau of Health Service Financing, and MCH coordinate in program development and data sharing. MCH is a Medicaid provider of EPSDT services, prenatal care, and case management. Local parish health units (PHU) determine eligibility for pregnant women to become Presumptively Eligible for Medicaid and assist pregnant women and children with the eligibility process for Medicaid and CHIP. PHUs continue to be the largest source of applications for Medicaid/CHIP. In large PHUs, Medicaid has out-stationed an eligibility worker to expedite applications for pregnant women, reducing the waiting time from as much as 45 days to 48 hours.

MCH advocated for and assisted Medicaid in preparing the data and information to convince policy makers to expand Medicaid coverage for pregnant women from 133% of the federal poverty guidelines to 200% in January 2003. Starting in November 2003, this includes dental coverage for pregnant women with periodontal disease. /2008/ Medicaid coverage for undocumented pregnant women was implemented May 2007.//2008// ***/2009/ MCH collaborates with Medicaid for Targeted Case Management, Nurse Family Partnership Program. //2009//***

MCH has a memorandum of agreement with the state Office of Addictive Disorders (OAD) to provide pregnancy testing and prenatal care referral for women served by OAD. MCH provides the test kits, training, and access to services of the PHU for pregnant women. Other collaboration includes assigning OAD substance abuse counselors to work with perinatal substance abuse programs in New Orleans and in Monroe. /2007/ A contract between MCH, OAD, and Ira Chasnoff, National Training Institute has been established to develop a statewide system addressing maternal substance abuse.//2007// ***/2009/ The state Office of Mental Health has been added to the collaboration adding maternal depression to the screening and referral portion of SBIRT initiative. WIC is now involved to provide a wider population of pregnant women to be screened for these behavioral disorders. //2009//***

Local PHU staff funded by MCH provides pregnancy testing, prenatal care and education, preventive child health services, presumptive eligibility and home visiting services statewide. WIC services are provided at the same time patients receive MCH prenatal and EPSDT services. PHU WIC patients who receive prenatal or child health care from private providers, receive health counseling, education, and referral from MCH funded staff. The state Title X Family Planning Program receives funding from MCH. Family Planning services are provided in PHUs and contract agencies statewide and are linked with prenatal services funded by MCH. Program directors of MCH, Family Planning, WIC, and other programs coordinate services and planning during regular OPH staff meetings. /2008/ Late 2006, the Family Planning Waiver began in Louisiana.//2008// ***/2009/ MCH is coordinating the evaluation for Louisiana's Family Planning Waiver. //2009//***

New Orleans has an independent health department and MCH funds maternal and child health services. MCH provides funding for the MCH Medical Director, MCH Nurse Consultant and an MCH Epidemiologist for the New Orleans Health Department. Six social workers were funded by MCH to expand the New Orleans Healthy Start project area. MCH funds a large prenatal clinic in a low-income neighborhood with Louisiana State University (LSU) Medical School providing the clinical services and the City of New Orleans providing the facility. MCH provides funding for prenatal care and/or pediatric services in primary care centers in Orleans, St. Charles, and Caddo parishes. Prenatal clinics, outreach, case management, and home visiting services are funded by MCH in the four Healthy Start grant project areas. /2007/ Due to the hurricane destruction in the New Orleans area, neighborhoods have been destroyed and many providers did not return. As a result, contracts have been discontinued or restructured to provide services in adjoining parishes.//2007// /2008/ MCH now funds a Fetal Infant Mortality Review nurse through the New Orleans Health Department's Healthy Start Program.//2008//

A key provider of MCH services across the state is LSU-HSC. LSU-HSC administers the services of the 9 state operated hospital located in each region of the state. MCH contracts with LSU-HSC in 4 of the 9 regions to provide prenatal care, nurse home visiting, case management, pediatric services, Fetal-Infant Mortality Review (FIMR), needs assessment and strategic planning. These activities comprise the Infant Mortality Reduction Initiative (IMRI) functions. In the remaining regions, the IMRI is coordinated by public and private hospitals, universities and social service entities. LSU Dental School collaborates with MCH to provide the Oral Health Director, Dental Consultant, and Fluoridation Coordinator to administer the state Oral Health Program. ***/2009/ MCH Oral Health Program collaborates with the federally qualified health centers to address access problems. //2009//***

Louisiana is one of five states participating in the Action Learning Lab (ALL), Tobacco Prevention

and Cessation for Women of Reproductive Age. MCH led the efforts for this collaboration along with the American College of Obstetricians and Gynecologists (ACOG) Louisiana, Planned Parenthood, Louisiana Public Health Institute (LPHI) and Medicaid. Information on smoking cessation and provider trainings was disseminated to over 200 ACOG providers. MCH contracts with LPHI to provide the evidence-based American Cancer Society's Make Yours A Fresh Start Family, a smoking cessation program for pregnant women. MCH participates in the State Infant Mortality (SIM) Collaborative. Five states are working to develop Tool Kits to address programs, policies, best practices and evidence based programs impacting infant mortality. The MCH Maternity Medical Director and Nurse Consultant collaborate with other groups on perinatal issues: Infectious Diseases, STD, HIV, Office of Addictive Disorders, OMH, School Based Health, American Cancer Society, March of Dimes, and faith-based initiatives.

MCH collaborates with the Louisiana Folic Acid Council to promote folic acid consumption to reduce the incidence of neural tube defects. MCH is represented on the Louisiana Council on Obesity Prevention and Management. The council's purpose is to study the issues relative to obesity in Louisiana, collect data on the subject, and develop recommendations for improving awareness regarding the health risks associated with obesity and suggesting modalities for treatment. Its membership includes DHH, the State DOE, the Pennington Biomedical Research Center and others. /2007/ The Folic Acid Council has been temporarily discontinued due to the relocation of the Council chair and coordinator.//2007//

Tulane University Health Sciences Center (TUHSC) collaborates with MCH to provide essential services. The SIDS Medical Director is a Pediatric Pulmonary Specialist in the TUHSC Department of Pediatrics. Evaluation, biostatistics, and health communication expertise is provided through contracts with the TUHSC School of Public Health and Tropical Medicine. Each semester at least 5 MPH students conduct their required internship in the MCH Program. ***/2009/ Tulane Department of Psychiatry provides faculty for infant mental health training and technical assistance for the Nurse Family Partnership Program. The Tulane University MCH Leadership Training grant is carried out in close collaboration with MCH state and local staff. //2009//***

The MCH Director and the Maternity Program Medical Director serve on the State Commission on Perinatal Care and Infant Mortality, standardizing the framework for regionalization of perinatal services by determining the level of hospital services provided. These standards are used by the Hospital Licensing Section and for Medicaid reimbursement. The MCH epidemiologists present findings from birth and infant death and PRAMS data analysis at the Commission meetings to inform policy decisions.

The Adolescent School Health Initiative Program regularly convenes the Intergovernmental Coordinating Council to assist in implementation, oversight, and funding assistance for school-based health centers. The Council is composed of representatives from the State DOE, OMH, OAD, the Excellence in Health and Education Project (EHEP) at Southeastern Louisiana University, the state Medicaid Office, DSS and other health service entities.

Childrens Special Health Services (CSHS) is uniting with established partner organizations, private providers, parents and other stakeholders to implement a Long Range Plan to providing services for children with special health care needs (CSHCN) statewide and also to strategize for the future direction of the CSHS Program. Agencies and organizations that participated in this collaboration in 2001 and continue to participate include Children's Hospital, Tulane Hospital for Children, Shriner's Hospital, statewide Families Helping Families members, private physicians, OPH, Medical Center of Louisiana at New Orleans, state congressional staff, as well as parents stakeholders. As a result of this collaboration and teamwork, CSHS contracted with LSU-HSC in 2003 to conduct a Statewide Needs Assessment that will describe the current access to health and related systems of care for the provision of comprehensive and coordinated care of children birth through 21 years in Louisiana. CSHS has begun regional planning with local stakeholders, medical representatives, OPH staff, other agencies and parents to formulate plans for future

CSHS services, as well services for all CSHCN in the community. /2008/ After hurricane Katrina, a redistribution of CHSCN families and physicians in the state accentuated pre-Katrina barriers to care, including lack of transportation and lack of accessible sub-specialists in rural areas. The CSHS long range plan addresses barriers to accessing healthcare for CSHCN by expanding care coordination and medical home activities and by addressing transition needs.//2008//

CSHS is also working in partnership with many agencies and organizations to address the need for primary health care services for all CSHCN in Louisiana. Since 2000, CSHS has collaborated with the Louisiana Chapter of the American Academy of Pediatrics to provide "Every Child Deserves a Medical Home" trainings. CSHS has taken leadership in planning meetings with local agencies and organizations including local hospitals, private providers, Medicaid, Social Security, Vocational Rehabilitation, State DOE, LSU Medical School, Tulane University Medical School and School of Public Health, ChildNet, Office of Citizens with Developmental Disabilities, Agenda for Children, Families Helping Families, Family Voices, City of New Orleans Health Department, health care organizations and parents. The OPH has directed each of the 9 OPH regions to plan and implement a strategy to address the issue of adequacy of primary care providers to serve CSHCN statewide. CSHS will continue to work with each of the remaining regions of the state as they plan for Medical Home. /2008/ After providing 4 regional conferences for health providers on medical home, CSHS shifted to ensuring that all pediatric residents trained in Louisiana at both LSU and Tulane Schools of Medicine understand medical home and comprehensive, family centered coordinated care. CSHS supports 2 models, a teaching clinic for residents in collaboration with Children's Hospital, LSU and the AAP, and a private pediatrician. CSHS clinics and model medical homes have developed collaborations with local agencies, including local departments of education, schools, Office of Mental Health, hospitals, OCDD, sub-specialists, social security, Families Helping Families, health care organizations, and various parent support groups.//2008//

CSHS is currently managing the EarlySteps program under Part C of Individuals with Disabilities Education Act. CSHS officially assumed responsibility for administering this early intervention program on July 1, 2003. Multiple agencies and stakeholders are represented on the State Interagency Coordinating Council, the entity that provides advice and assistance to EarlySteps. CSHS continues to partner with these agencies and individuals, focusing on Personnel Preparation, Service Coordination, Finance and Public Relations for the EarlySteps Program.

CSHS and EarlySteps are also collaborating to develop interagency agreements with several agencies. Negotiations are in progress with the State DOE, Office of Health Services Financing, Office of Citizens with Developmental Disabilities and Bureau of Health Services Financing (Medicaid) to ensure a coordinated system of early intervention services. /2008/ CSHS is transitioning Early Steps program under Part C of IDEA to Office for Citizens with Developmental Disabilities on July 1, 2007. CSHS will continue to be active with SICC and its agencies. CSHS' collaboration with OCDD will continue efforts to coordinate services for CSHCN, including early intervention services, waiver services and personal care services provided by OCDD. CSHS continues to use a joint application for CSHS, EarlySteps, Medicaid and OCDD services. This helps ensure coordination of services between agencies. CSHS is working with Medicaid to increase reimbursement for care coordination, both in private pediatric offices and in CSHS clinics.//2008// ***/2009/ The CSHS Director is on the Advisory Board of the Healthcare Quality Forum (LHCQF), legislatively mandated to implement Medical Home (MH). CSHS presented its data on CC in the MH at a MH Summit by LHCQF attended by 115 invited policy makers. DHH will model its healthcare system after Florida's capitated system of Provider Service Networks (PSN's), with CC contracted out. CSHS will continue to assist MH's with CC and is exploring its interface with Medicaid, OCDD, DSS and PSN's in the new system. //2009//*** CSHS works with WIC to establish procedures of identifying children eligible for Part C services and expediting referrals to the Part C Systems Point of Entry locations. CSHS plans to continue this ongoing partnership to assist in the identification of children and in providing services for CSHCN.

In addition, CSHS has been working in partnership with LSU School of Medicine to provide services for children of mothers who are substance abusers. CSHS funding is supporting the services of a Developmental Specialist who provides clinical services for identified children in clinics at University Hospital in New Orleans. In addition to assessments, this clinic provides information, referrals and follow-up to programs and agencies as determined by the needs of the child and family.

CSHS has also pooled resources with Children's Hospital to establish a model program dedicated to the specialized care of children with diabetes in Louisiana, with a focus on prevention of acute and chronic complications. This program provides the team services of a pediatric diabetologist, pediatric diabetes nurse educator, pediatric nutritionist, pediatric psychologist, exercise trainer and visiting pediatric diabetes liaison nurse. The goal of this program is to reduce emergency room visits, improve growth and development of the children, as well as decrease the average blood glucose level of the enrolled children. /2008/ CSHS will fund a nurse coordinator for pediatric rehabilitation clinics at Children's Hospital to provide care coordination services in the clinics.//2008//

CSHS, LSU Dental School and Children's Hospital have jointly provided funding for the Special Children's Dental Clinic at Children's Hospital. LSU Dental School staffs the clinic with pediatric dentists, dental students and dental support staff. CSHS provides funding for clinical services. This clinic services CSHCN from the 9 statewide CSHS clinics, as well as private clients.

CSHS is implementing the Birth Defects Monitoring Network. This name emphasizes partnering with other projects and agencies to ensure success of the program. The Advisory Board consists of 9 members including representatives from the Louisiana State Medical Society, Ochsner Foundation Medical Center, Tulane University Medical Center, LSU-HSC, March of Dimes, MCH Coalition, OPH, a parent representative and a consumer representative. At present, Louisiana has hired surveillance staff for the program in a partnership with LPHI. ***/2009/ LBDMN also partners with Lake Charles Memorial Hospital for surveillance staff and Spina Bifida Association of GNO for its advisory board. LBDMN works closely with MCH for systems development. //2009//*** The Hearing, Speech and Vision Program (HSV) within CSHS works closely with all birthing hospitals in the state to ensure hearing screening for all newborns. CSHS also collaborates with private audiologists and the medical community for follow-up evaluations or for families with lack of insurance or no access to local community services. The State Advisory Council for Newborn Hearing Screening is appointed by the Governor and includes 14 stakeholders and advises the program on the EHDI system in the state. ***/2009/ EHDI works with LA chapters of the Association of the Deaf, Commission for the Deaf, Hospital Association, AAP, AAFP, Speech/Language Hearing Association, American Speech/Language Hearing Association, American Academy of Audiology, Speech Pathologists and Audiologists in LA Schools, and Board of Examiners for Speech Pathology and Audiology. //2009//***

The CSHS Program Manager participates in the State Planning Council for Developmental Disabilities in Louisiana. Other members of this council include the Advocacy Center, LSU-HSC Center for Excellence in Developmental Disabilities, self advocates, parents, State DOE, OMH, Office for Citizens with Developmental Disabilities, Louisiana Rehabilitation Institute, Governor's Office on Disability Affairs, Governor's Office on Elderly Affairs and others. This ongoing collaboration addresses issues related to all aspects of life for persons with disabilities. ***/2009/ The CSHS Director is on the Developmental Disabilities Council. //2009//***
/2007/ In the aftermath of the disasters, collaboration with community partners provided much needed assistance for the CSHS program. Agencies such as Families Helping Families, the Southeast Area Health Education Authority, Easter Seals, and Children's Hospital provided temporary office space and resources for displaced CSHS staff. In addition, many agencies such as Families Helping Families visited Special Needs Shelters providing resources to families with CSHCN displaced by the disasters. The national Family Voices office also provided financial assistance directly to some affected families.//2007//

F. Health Systems Capacity Indicators

Introduction

Health Systems Capacity Indicators are used as a monitoring/assessment tool. They are used to measure the state's effectiveness in maintaining or improving the overall health of the state's population of pregnant women, women of child bearing age, infants, children and children with special health care needs. State MCH efforts have been successful in improving early and adequate prenatal care. Examination of the data for disparities is vital in order to tailor efforts to reach out to populations and areas in greatest need, in order to make further progress. There are concerns post-Hurricanes about the capacity of the state's health service infrastructure to provide adequate services and the HSCI enables such monitoring.

The goal of the State System Development Initiative (SSDI) grant is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions. Data is used as an indicator for developing new strategies and efforts to address emerging population needs.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	52.0	74.4	60.3	60.3	60.3
Numerator	1685	2388	1817	1817	1817
Denominator	323991	320790	301375	301375	301375
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

Data is based upon 2005 Louisiana Hospital Inpatient Discharge Data (LAHIDD).Data is provisional, based on 2005. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator.
Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. The variability limits year-to-year comparison analyses. Also, since the CDC has changed the 2004 Census population data for Louisiana from 4,515,770 to 4,506,685, then the 2004 statistics reported are based on the new population data.

Notes - 2006

Data is based upon 2005 Louisiana Hospital Inpatient Discharge Data (LAHIDD).Data is provisional, based on 2005. Since 2002, the primary data source of analysis and reporting for this

indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator.
Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. The variability limits year-to-year comparison analyses. Also, since the CDC has changed the 2004 Census population data for Louisiana from 4,515,770 to 4,506,685, then the 2004 statistics reported are based on the new population data.

Notes - 2005
Data is based upon 2005 Louisiana Hospital Inpatient Discharge Data (LAHIDD). Data is final. Since 2002, the primary data source of analysis and reporting for this indicator is the Louisiana Hospital Inpatient Discharge Data (LAHIDD). LAHIDD is compiled by the Health Statistics Department of the Louisiana Office of Public Health, and EMS/Injury Research and Prevention Program analyzes the data needed for this indicator.
Since participation in reporting hospital inpatient discharge data is not mandatory in Louisiana, then differences in the number, size, and type of hospitals reporting annually will affect our data reported. The variability limits year-to-year comparison analyses. Also, since the CDC has changed the 2004 Census population data for Louisiana from 4,515,770 to 4,506,685, then the 2004 statistics reported are based on the new population data.

Narrative:
/2009/ Based on final 2005 Louisiana data, the rate of children under 5 years of age hospitalized for asthma in 2005 is 60.3 per 10,000 children less than age 5 years. Hospital Discharge Data for 2006 and 2007 are not yet available. //2009//
In 2004, the rate of children hospitalized for asthma is 74.4 per 10,000 children less than five years of age. This rate is higher than the rates in 2001 (67.9 per 10,000), 2002, (61.4 per 100,000), and 2003 (52 per 10,000). Hospital discharge data for 2005 and 2006 are not yet available for comparison.

Some factors influencing this indicator are the use of best practices for outpatient management of childhood asthma; (increased) access to medications and medical care; and the education of parents/caregivers on how to reduce exposure to asthma triggers.
/2009/ Louisiana uses the Behavior Risk Factor Surveillance System (LABRFSS) and the Youth Tobacco for data on childhood asthma prevalence data are used by DHH Chronic Disease Program and Louisiana Medicaid's LaCHIP continues its performance monitoring of the use of appropriate asthma medications as one of its core quality measures. //2009//

The state uses its Behavior Risk Factor Surveillance System (LA BRFSS) to gather annual data on asthma prevalence, and, as one of its core performance measures, Louisiana Medicaid Program tracks the use of appropriate medications for children with asthma. Information from the Louisiana Medicaid performance monitoring on asthma showed that the use of appropriate medications in children with asthma increased from 60.79% in 2003 to 66.27% in 2004.

Louisiana is committed to asthma management in children. The MCH Program supports the state's efforts to reduce childhood asthma through education and outreach efforts to parents, healthcare providers, and in school-base health centers. One of Louisiana CommunityCARE's quality projects is "Achieving Better Care for Asthma". The goals of this statewide project are to promote healthy behaviors in our Medicaid population resulting in improved health outcomes; to improve medical home management by providing education, office management tools, and utilization data to providers; and to develop patient self-care through education. Also, the MCH Program supports Medicaid and LaCHIP's efforts to enroll eligible children into the respective program to increase children's access to healthcare.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	87.7	88.7	87.5	89.8	90.2
Numerator	38174	40591	40441	40505	43931
Denominator	43551	45770	46225	45119	48707
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2006 - 09/30/2007. Since Louisiana's SCHIP program is through Medicaid expansion, the numerator and denominator Include children enrolled in LaCHIP.

Notes - 2006
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2005 - 09/30/2006. Since Louisiana's SCHIP program is through Medicaid expansion, the numerator and denominator Include children enrolled in LaCHIP.

Notes - 2005
From Louisiana Medicaid Management Information Systems, HCFA 416 , for dates of service 10/01/2004 - 09/30/2005. Since Louisiana's SCHIP program is through Medicaid expansion, the numerator and denominator Include children enrolled in LaCHIP.

Narrative:
/2009/ The percent Medicaid enrollees under age 1year who received at least one periodic screen increased to 90.2% in 2007. //2009//
There was no significant change in the percent of Medicaid enrollees less than one year of age who received at least one initial periodic screen. The rate increased from 88.7% in 2004 to 88.6% in 2006. However, from 2001 to 2006, there was an overall increase from 86.9% to 88.6%.This indicator reflects the capacity of Louisiana's healthcare system to provide services, which include provider enrollment; opportunities to access preventive healthcare services with a primary care physician; and patient utilization of accessible services.

Medicaid and LaCHIP recipients in Louisiana are enrolled in the Department of Health and Hospitals' (DHH) CommunityCARE Program, which is a comprehensive health delivery system that links recipients to a primary care physician, creating a "medical home". The participating physicians provide enrolled children with preventive care, including periodic screens, outpatient and hospital inpatient care, health education, and referrals to specialists.

The MCH Program will continue to support delivery of preventive health services, such as health screenings, immunizations, and parental education, to low income infants and children in the state's public health clinics, school base health centers, and contract clinics; screen infant and children seen in the public health clinics for Medicaid eligibility; provide technical assistance to the Medicaid program on issues related to access to services for children; and promote the Medical Home concept, through Louisiana's Early Childhood Comprehensive Systems Initiative and

collaboratively with the Louisiana Chapter of the American Academy of Pediatrics.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	86.5	86.4	86.4	53.6	89.3
Numerator	536	515	459	260	509
Denominator	620	596	531	485	570
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Data is provided by the Medicaid Office.

Notes - 2006
Data is provided by the Medicaid Office.

Notes - 2005
Data is provided by the Medicaid office.

Narrative:
/2009/ The percentage of LaCHIP enrollees under age one year who received at least one periodic screen in 2007 was 89.2%, which is higher than the rate of 53.6% in 2006 and 86.4% in years 2005 and 2004. //2009//

The percentage of LaCHIP enrollees whose age was less than one year who received at least one periodic screen for 2006 was 53.6%. Decreased access to services due to the loss of healthcare providers and the displacement of citizens resulting from Hurricane Katrina may explain this decrease. The percentage was unchanged for 2004 and 2005 at 86.4%.

This indicator reflects the capacity of Louisiana's healthcare system to provide services, which include provider enrollment; opportunities to access preventive healthcare services with a primary care physician; and patient utilization of accessible services. Louisiana has continued its aggressive outreach efforts by the La. Covering Kids Coalition since 2003, to enroll eligible children into the LaCHIP and Medicaid Programs. By July 2005, more than 45,000 children were enrolled into LaCHIP, which increased their access to providers and preventive health screens. Enrollment efforts continued immediately post-Hurricane Katrina to enrolled eligible evacuees, including those displaced from Louisiana.

LaCHIP recipients are enrolled in the DHH CommunityCARE Program, which is a comprehensive health delivery system that links recipients to a primary care physician, creating a "medical home". The participating physicians should provide enrolled children with preventive care, including periodic screens, outpatient and hospital inpatient care, health education, and referrals to specialists.

The MCH Program will continue to: support delivery of preventive health services, such as health

screenings, immunizations, and parental education in the state's public health clinics, school base health centers, and contract clinics; screen infants and children seen in the public health clinics for LaCHIP and Medicaid eligibility; provide technical assistance to the Medicaid program on issues related to access to services for children; and promote the Medical Home concept, through the Louisiana's Early Childhood Comprehensive Systems Initiative and with the Louisiana Chapter of the American Academy of Pediatrics.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	89.9	90.3	89.7	90.0	90.0
Numerator	57994	58460	53901	56026	56026
Denominator	64500	64769	60109	62266	62266
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Narrative:
The 2005 indicator was 89.9%. This was a drop from the 2004 level of 90.3%. Prenatal care access and utilization serves several important roles in monitoring the maternity population. First, it may serve as an indicator of overall prenatal services. This includes availability, provider willingness to accept Medicaid, and transportation to care issues. The second important issue is patient utilization of services and awareness of benefits of care. This is a marker for patient education activities and their results. While it might be assumed that improved care will result in lower infant mortality rates, there does not appear to be a direct correlation.

/2009/ The final 2005 data was 89.7% and the preliminary 2006 data is 90.0%. The hurricanes of 2005 resulted in marked disruption of prenatal care access, especially in southern Louisiana. This disruption of access and in-migration of immigrant (primarily Hispanic) populations have resulted in new challenges for early and adequate prenatal care. The MCH program has been working diligently with partners throughout the state to assure access. //2009//

New data linkages are developed with Louisiana Hospital Inpatient Discharge Data (LaHIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are established to access to the Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data. Prenatal visits are one of the data collected and analyzed. ***/2009/ PRAMS collection and analysis was disrupted for a year following the 2005 hurricanes but has now resumed. //2009//***

Prenatal care rates in Louisiana have been improving, but no associated drop in mortality rates have been seen. The current decrease in rate is concerning and one being discussed and addressed by program activities. The majority of births in Louisiana are to Medicaid mothers, Louisiana physicians typically will accept Medicaid and these private providers see most patients

in the state. Thus, availability of care is present in most areas. The MCH program works within the public health unit system to provide prenatal care in areas where private and other public providers are not available. The Partners for Healthy Babies media campaign targets prenatal care as one of its primary messages to promote improvement in this area. The statewide Fetal and Infant Mortality Reduction Initiative (IMRI) targets prenatal care as one of its areas of improvement. ***/2009/I n the continuing aftermath of the 2005 hurricanes, prenatal care access continues to be a challenge for some, especially minority and immigrant populations. The MCH program continues providing care through public health units in regions with provider shortages and works with partners to secure access as possible. Work with the March of Dimes has resulted in mobile prenatal vans and Centering Pregnancy groups. //2009//***

The goal of the State System Development Initiative (SSDI) grant is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems will enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	85.8	92.3	92.3	83.2	85.5
Numerator	617784	642442	666584	636648	645924
Denominator	719640	696077	721919	764825	755539
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

For 2006 and 2007, data was obtained from the Louisiana Department of Health and Hospitals Medicaid Annual Reports for State Fiscal Year 2005/2006 and 2006/2007. The numerator is the (unduplicated) number of all Medicaid children (Title XIX and XXI) under age 19 years who received at least one processed claim during the period involved, whether or not he/she was enrolled on the date the claim was paid but was enrolled at the time the service for the claim was provided. The denominator is the number of all children who applied and have been approved to receive services, regardless of whether he/she received services and/or any claims have been filed on his/her behalf. Therefore, any post-annual report data of all Medicaid children's enrollment, recipients of service(s), and/or total costs of received services received for a specific state fiscal year, which is obtained after the date of the data used for the Medicaid report, will differ from the data in the report because retroactive eligibility will be included in the new figures.

Notes - 2006

For 2006 and 2007, data was obtained from the Louisiana Department of Health and Hospitals Medicaid Annual Reports for State Fiscal Year 2005/2006 and 2006/2007. The numerator is the

(unduplicated) number of all Medicaid children (Title XIX and XXI) under age 19 years who received at least one processed claim during the period involved, whether or not he/she was enrolled on the date the claim was paid but was enrolled at the time the service for the claim was provided. The denominator is the number of all children who applied and have been approved to receive services, regardless of whether he/she received services and/or any claims have been filed on his/her behalf. Therefore, any post-annual report data of all Medicaid children's enrollment, recipients of service(s), and/or total costs of received services received for a specific state fiscal year, which is obtained after the date of the data used for the Medicaid report, will differ from the data in the report because retroactive eligibility will be included in the new figures.

Notes - 2005
The numerator is data provided by the Louisiana Medicaid Program, which is the (unduplicated) number of Medicaid recipient children under age 19 years who received a medical service during FFY 2003-2004, by date of service, in which CommunityCARE fees are not considered paid claims. The denominator, which is from the American Academy of Pediatrics' Children's Health Insurance Status and Medicaid/ SCHIP Eligibility and Enrollment, 2004: State Reports (September 2005), is an estimate of the number of U.S. children through age 18 eligible for Medicaid/State Child Health Insurance Program.

Narrative:
/2009/ The percentages of potentially Medicaid-eligible children who received a paid service by Medicaid are 83.2% in 2006 and 85.5% in 2007, which are both less than 92.3% in 2005. //2009//
The percent of potentially Medicaid-eligible children who have received a paid service by Medicaid in 2005 was 92.3%, which is unchanged from 2004. There was an overall increase in the percent of potentially Medicaid-eligible children who have received a service paid by Medicaid from 70.7% in 2001 to 92.3% in 2005. Data is not yet available for 2006. This indicator reflects the following: enrollment of eligibles; Louisiana's healthcare system's capacity to provide services, including healthcare provider enrollment; accessibility to preventive healthcare services with a primary care physician; and patient utilization of accessible services.

Medicaid recipients in Louisiana are enrolled in the Department of Health and Hospitals' CommunityCARE Program, a comprehensive health delivery system that links recipients to a primary care physician, creating a "medical home". The participating physicians provide enrolled children with preventive care, including periodic screens, outpatient and hospital inpatient care, health education, and referrals to specialists. Positive strides were made to increase the adequacy of primary care for Medicaid enrollees, primarily by extending eligibility criteria for health insurance to children and increasing enrollment of eligibles into the Medicaid Program. However, health insurance alone cannot reduce the inequities in healthcare access. Therefore, beyond expanding health insurance coverage for children, further efforts are also needed to increase patient utilization of services and healthcare provider participation in the Medicaid Program.

The MCH Program continues to support delivery of preventive health services, such as health screenings, immunizations, and parental education in state public health clinics, school base health centers, and contract clinics; screen infants and children seen in the public health clinics for LaCHIP and Medicaid eligibility; provide technical assistance to the Medicaid program on issues related to access to services for children; and promote the Medical Home concept, through the Louisiana's Early Childhood Comprehensive Systems Initiative and with the Louisiana Chapter, American Academy of Pediatrics.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	39.4	41.5	42.0	40.2	40.4
Numerator	53553	59417	62777	58224	62241
Denominator	135807	143106	149564	144751	153948
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
From Louisiana Medicaid Management Information Systems, HCFA 416, for dates of service 10/01/2006 - 09/30/2007.

Notes - 2006
From Louisiana Medicaid Management Information Systems, HCFA 416 , for dates of service 10/01/2005 - 09/30/2006.

Notes - 2005
From Louisiana Medicaid Management Information Systems, HCFA 416 , for dates of service 10/01/2004 - 09/30/2005.

Narrative:
The Louisiana Medicaid Management System (2005 -- 2006) reports that 37% of 6 through 9 year olds have received any dental services during the year. This data reflects a decrease in the percentage of children receiving services from the previous year's data. Louisiana has over 2000 practicing dentists, however, only 392 dentists are actively participating ($10,000 or more in Medicaid claims). ***/2009/ The Louisiana Medicaid Management System (2006 -- 2007) reports that 27% of 6 through 9 year olds have received any dental services during the year. Louisiana has over 2000 practicing dentists, however, only 410 dentists are actively participating ($1000 or more in Medicaid claims) as Medicaid providers, according to the 2007 American Dental Association Annual Survey. //2009//***

In our effort to increase dental health care utilization, the Oral Health Program's school-based dental sealant program is expanding to include both rural and urban schools where access to care is a challenge and dental health needs are great. The sealant program expanded to new parishes including Evangeline, Catahoula, Avoyelles, and East Baton Rouge and continued in Allen, Caddo, East Feliciana and Desoto parishes. Current program data reveals that 889 children have been screened and 2413 dental sealants have been placed (not all schools reported). The Health Enrichment Network, an organization for health care advocacy, partnered with MCH to provide volunteer dentists to do screenings. The organization also donated dental supplies. MCH partnered with Health Care Centers in Schools (Coordinated School Health Services) and the Louisiana Dental Association to participate in Give Kids a Smile Day, which is a community outreach project sponsored by the American Dental Association. Two East Baton Rouge parish schools and 1 school in Acadiana Parish participated. Over 150 students received oral health education, dental screenings, and dental sealants. ***/2009/ The sealant program expanded in Rapides Parish School-based Health Centers. Sealant program activities were coordinated by the Oral Health Program's community partners in central Louisiana. Program efforts continued in Allen, Avoyelles, Catahoula, Concordia, Evangeline, and East Baton Rouge parishes. Current program data reveals that 2400 children have been screened and 1800 dental sealants have been placed (data includes parishes reported as***

of 06/5/08). Four East Baton Rouge parish schools participated. Over 200 students received oral health education, dental screenings, and dental sealants. //2009//

In addition to providing the dental sealant program, the OHP staff will continue to work with community health centers, School-based Health Centers and private practitioners to ensure that the children secure a 'dental home'.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Indicator	5.8	4.6	8.4	5.6	4.3
Numerator	1486	1228	2058	1400	1101
Denominator	25443	26671	24448	25036	25541
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007
Source for 2007 numerator is Medicaid. The Denominator is from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table: "Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2007."

Notes - 2006
Source for 2006 numerator is Medicaid. The Denominator is from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table: "Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2006."

Notes - 2005
Source for 2005 numerator is Medicaid. The Denominator is from the Social Security Administration, Supplemental Security Record (Characteristic Extract Record format), 100 percent data. Table: "Number of children under age 16 receiving federally administered SSI payments, by state or other area, December 2005."

Narrative:
This capacity indicator is based on the capacity of the CSHS program in providing direct care to children. Because the eligibility of the program is restricted financially and medically, not all children with SSI may qualify medically for CSHS. In addition, many are able to access Medicaid services in their community. One influencing factor on this indicator is the availability of Medicaid providers in individual communities. When services are available, fewer children need to access CSHS services.

The reporting of this indicator is also influenced by data collection. Because of the way Medicaid structures their eligibility cards, it is not clear which children are SSI recipients. Data has been

obtained from Medicaid which is an overestimate of the population. ***/2009/ Correction: This data includes only children with SSI disability, as reported by the SSI Disability Determinations office. It is not an over estimation as previously thought. //2009//***

With the development of care coordination activities in CSHS, more children will receive these services. SSI will be able to refer for care coordination just as other sources. Regional CSHS offices currently have working relationships with their Medicaid and SSI offices. Limited eligibility will remain a factor in improving this indicator.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2006	matching data files	12.9	8.6	11.5

Narrative:
Medicaid is the federal and state health care funded program primarily to serve to increase access and provide care for otherwise unfunded citizens. This implies that the Medicaid population may have higher risks, such as increased poverty, poorer access to care, less education opportunities, and higher utilization of substances as compared to the non-Medicaid population who would be assumed to have commercial insurance. This does not account for populations of undocumented immigrants who typically have no coverage, and may have risks similar or higher than the Medicaid population. By comparison of the two groups, indicators of areas to target for intervention result. Reflective of these increased risks, the low birth weight rate for the Medicaid population is significantly higher than the non-Medicaid population (2005- 13.4% vs. 8.0% respectively). The overall low birth weight rate for 2005 was 11.5% as compared to 11.0% for 2004. ***/2009/ The final 2005 overall percent of low birth weight was 11.5%, with the Medicaid population rate of 13.4% and the non-Medicaid rate of 8.2%. Preliminary 2006 data shows the overall rate of 11.5%, Medicaid rate of 12.9% and non-Medicaid rate of 8.6%. Following the hurricanes of 2005, significant population shifts and additional stressors were seen in Louisiana families. It is felt that these events could lead to increased rates of low birth weight births. Additionally, a significant number of immigrant families have entered the state. The state Medicaid program did begin prenatal care coverage of undocumented individuals through the LaCHIP program. //2009//***

Low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing low birth weight infants, by regions and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, a general measure of risks and results of interventions are obtained. Specific interventions include the IMRI, smoking cessation program, dental services program, substance abuse and depression screening programs. New data linkages are developed with Louisiana Hospital Inpatient Discharge Data (La HIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are established to access to the Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data. ***/2009/ The SBIRT program***

screening for alcohol use, tobacco use, substance abuse, depression and domestic violence in pregnancy is active in 4 of 9 regions of the state. Program implementation in 2 other regions will occur by mid-2008 and all regions are expected to be screening by 2009. This program targets screening in both the public and private sectors. Plans are being developed to implement screening in WIC clinics also. A family planning waiver, Take Charge, is providing increased access to services for Medicaid eligible women. //2009//

The goal of the State System Development Initiative (SSDI) grant is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems will enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2006	matching data files	10.8	7.6	9.7

Narrative:
The 2005 preliminary infant death rate of the Medicaid population was 11.9 compared to 6.6 for the non-Medicaid population. The infant death rate for all groups dropped to 10.0 in 2005 as compared to 10.4 in 2004. Medicaid is the federal and state health care funded program primarily to serve to increase access and provide care for otherwise unfunded citizens. This implies that the Medicaid population may have higher risks, such as increased poverty, poorer access to care, less education opportunities, and higher utilization of substances as compared to the non-Medicaid population who would be assumed to have commercial insurance. This does not account for populations of undocumented immigrants who have no coverage, and may have risks similar or higher than the Medicaid population. By comparison of the 2 groups, indicators of areas to target for intervention result. Infant mortality serves as a broad marker of health status and health care utilization for women and children. Many factors contribute to infant mortality, but preterm births, especially those less than 1500 grams, contribute heavily to the measure. While it is a broad marker, it is one that is commonly recognized and utilized by the general public. It provides valuable comparison of a state over time, and by trending, can serve as a marker for intervention success. It is important in evaluation of specific groups, as in the disparity present in African American and white births. Comparison between regions, states, and other countries of this marker are common. The infant death rate in Louisiana has generally been increasing over the last decade. Multiple interventions have begun, including the IMRI project, FIMR in each region, collaboration with other state agencies (Medicaid, Mental Health, Addictive Disorders), and smoking/addictive disorder screening and treatment. Active involvement with Louisiana ACOG, the private Louisiana MCH Coalition, and the state Perinatal Commission is ongoing. ***/2009/ The final 2005 data for infant death rate was 10.1 overall, with the Medicaid population rate of 12.1 and non-Medicaid rate of 6.8. The preliminary data for 2006 reveals an overall rate of 9.7, with a Medicaid rate of 10.8 and non-Medicaid rate of 7.6. The improvement in Medicaid rate may be due to several identified factors. First, the IMRI project and regional FIMR groups have placed increased regional focus on infant***

mortality, preterm births, and racial disparities. Multiple interventions have begun to address these issues. Additionally, following the 2005 hurricanes there has been a decrease in African American births, primarily due to population shifts. Issues concerning access to care, and increased stressors, may still have some adverse impacts on the infant mortality rate. MCH is working to identify and alleviate these adverse factors. A family planning waiver, Take Charge, is providing increased access to services for Medicaid eligible women. //2009//

The goal of the State System Development Initiative (SSDI) grant is to enhance the data capacity of Louisiana's Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) Programs. Improving existing and establishing new data linkages and surveillance systems will enhance data capacity. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses by MCH and CSHCN Programs, which identify priority needs for programs and interventions. New data linkages will be developed with Louisiana Hospital Inpatient Discharge Data (La HIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are established to access to the Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	83.1	94.9	87.1

Narrative:
The Medicaid population rate was 82.5 compared to 95.8 among the non-Medicaid population. ***/2009/ The Medicaid population rate was 83.1 compared to 94.9 among the non-Medicaid population. //2009//*** MCH program funds direct prenatal services to indigent pregnant women especially in areas where there are access to care problems. The statewide MCH Partners for Healthy Babies Social Marketing campaign promotes early prenatal care through all of its activities, including multimedia and other communication strategies. Fetal & Infant Mortality Review Initiatives (FIMR) have been established in all regions of the state. The program (staff and coalition structure) is charged with assessing service delivery gaps including prenatal care. The Nurse Family Partnership, nurse home visiting program provides case management services for first time mothers statewide, assuring early and adequate care for its enrollees.

The Fetal and Infant Mortality Reduction (FIMR) programs, through the Community Action Teams, are becoming Regional Forums, serving as umbrella organizations within the community for MCH issues. Regional FIMRs are expanding focus on diversity and cultural competence in strategic planning for the Community Action Teams. Parishes in the lowest quartile for first trimester entry into prenatal care are targeted by Regional IMRI Community Action Teams for the development of additional prenatal initiatives. OPH has partnered with the March of Dimes to

implement regional CenteringPregnancy Programs. One initiative targets Latina clients; others are in areas where there is inadequate access to prenatal care. Needs Assessment for Native American tribal groups is ongoing in collaboration with the Bureau of Minority Affairs. Collaboration with Medicaid is expanding. Plans to expand and update the Partners for Healthy Babies (PHB) website are underway. ***/2009/ The Partners for Healthy Babies (PHB) website and helpline are being coordinated with local FIMR resources. //2009//*** In addition PHB is training and supporting the regional FIMR Coordinators in public relations efforts/activities.

State MCH efforts have been successful in improving early and adequate prenatal care. It is vital to examine the data for disparities in order to tailor efforts to reach out to populations and areas in greatest need, in order to make further progress. Concerns post-Hurricane Katrina are in terms of capacity of state's health service infrastructure to provide prenatal services and this is being monitored.

Using our SSDI Coordinator, the MCH program has gone to great lengths to research sources of data. The SSDI Coordinator has obtained agreements and data sets external to the MCH program but internal to the Department of Health Hospitals, such as Health Statistics/Vital Records and Medicaid. These data sets include those that measure women receiving prenatal care beginning in the first trimester.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2006	matching data files	89	91.9	90

Narrative:
The rate for the Medicaid population was 88.5% compared to 92% for the non-Medicaid population. ***/2009/ The rate for the Medicaid population was 88.5% compared to 92% for the non-Medicaid population. //2009//*** MCH program funds direct prenatal services to indigent pregnant women especially in areas where there are access to care problems, The statewide MCH Partners for Healthy Babies Social Marketing campaign promotes early prenatal care through all of its activities, including multimedia and other communication strategies. Fetal & Infant Mortality Review Initiatives (FIMR) have been established in all regions of the state. The program (staff and coalition structure) is charged with assessing service delivery gaps including prenatal care. The Nurse Family Partnership, nurse home visiting program provides case management services for first time mothers statewide, assuring early and adequate care for its enrollees.

The Fetal and Infant Mortality Reduction Initiative (FIMR) exists in each region of the state. Regional FIMRs are expanding focus on diversity and cultural competence in strategic planning for the Community Action Teams. Parishes in the lowest quartile for first trimester entry into

prenatal care will be targeted by Regional IMRI Community Action Teams for the development of additional prenatal initiatives. OPH has partnered with the March of Dimes to implement regional CenteringPregnancy Programs, one of which targets our Latina clients. Needs Assessment for Native American tribal groups is ongoing in collaboration with the Bureau of Minority Affairs. Collaboration with Medicaid is expanding. Plans to expand and update the Partners for Healthy Babies (PHB) website are underway. In addition PHB will train and support the regional FIMR Coordinators in public relations efforts/activities.

State MCH efforts have been successful in improving early and adequate prenatal care. It is vital to examine the data for disparities in order to tailor efforts to reach out to populations and areas in greatest need, in order to make further progress. Concerns post-Katrina/Rita, are in terms of capacity of state's health service infrastructure to provide prenatal services and this is being monitored carefully.

Using our SSDI Coordinator, the MCH program has gone to great lengths to research sources of data. The SSDI Coordinator has obtained agreements and data sets external to the MCH program but internal to the Department of Health Hospitals, such as Health Statistics/Vital Records and Medicaid. These data sets include those that measure women receiving adequate prenatal care.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2007	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2007	200

Notes - 2009

Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan.
For all children ages 0 through 19 years, the percent of poverty level for eligibility in Louisiana Medicaid and LaCHIP is up to 200% at no cost.

Narrative:

/2009/ For infants (0 to 1 year), the percent of poverty level for eligibility in the State's Medicaid Program is up to 200%, and the percent of poverty level for the LaCHIP Medicaid expansion program is up to 200%. Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan. //2009//

For infants, the percent of poverty level for eligibility in the State's Medicaid Program is 133%. The percent for the LaCHIP Program is now 300%, which expands health insurance eligibility requirements. Health insurance expansion is necessary to improve children's access to healthcare, which may improve the health status of low-income children.

Poverty levels can be a broad measure of the health status and welfare of infants and children. Eligibility rules help the state and MCH Program assess needs of children based on the estimated

number of children eligible to participate in Medicaid and LaCHIP programs but who remain uninsured.

The MCH Program will continue to support activities to mitigate the adverse affects of poverty on an infant and child's physical, cognitive, emotional, and behavioral development by driving policy making efforts at the state level, especially through active involvement in healthcare reform efforts and through the ECCS Initiative and the Governor's Children's Cabinet; supporting direct preventive health services at the public health units; and addressing our current MCH priority needs.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children (Age range 1 to 5) (Age range 6 to 14) (Age range to)	2007	 200 200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2007	 200

Notes - 2009
Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan.
For all children ages 0 through 19 years, the percent of poverty level for eligibility in Louisiana Medicaid and LaCHIP is up to 200% at no cost.

Narrative:
/2009/ For all children ages 0 through 19 years, the percent of poverty level for eligibility in Louisiana Medicaid and LaCHIP is up to 200% at no cost. Since April of 2008, families with incomes between 200 and 250 percent of FPL will be able to obtain health coverage at an affordable monthly premium and with co-payments through the new LaCHIP Affordable Plan. //2009//
For children, the percent of poverty level for eligibility in the Medicaid Programs for all ages is 133% for 1-5 years of age and 100% for 6-14 years. The LaCHIP program expands health insurance eligibility requirements for all ages to 300 percent of the poverty level. Health insurance expansion is necessary to improve children's access to healthcare, which may improve the health status of low-income children.

Poverty levels can be a broad measure of the health status and welfare of infants and children. The state and MCH Program can assess needs of children based on the estimated number of eligibles who participate in Medicaid and evaluate the estimated number of eligibles who qualify for participation in either program but remain uninsured.

The MCH Program will continue to support activities to mitigate the adverse affects of poverty on

an infant and child's physical, cognitive, emotional, and behavioral development by driving policy making efforts at the state level, especially through active involvement in healthcare reform efforts and through the ECCS Initiative and the Governor's Children's Cabinet; supporting direct preventive health services at the public health units; and addressing our current MCH priority needs.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2007	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women		

Notes - 2009
Pregnant women are covered under the state's LaMOMS program. This program is a standard Medicaid program and is not covered by SCHIP funds.

Narrative:
The ability to maintain and/or improve eligibility levels are influenced by the state budget.

Expansion of prenatal care coverage through the SCHIP (Title XXI) program (Effective May 1, 2007) is a recent strategy implemented to expand children's health insurance by providing coverage eligibility for non-citizen pregnant women who are not otherwise eligible for Medicaid. The coverage is for prenatal care for this population.

Expansion of family planning through the Family Planning Waiver is a recent strategy for program expansion to residents. Ongoing discussion Medicaid and the State Budget officials to improve eligibility levels continue. ***/2009/ The Louisiana Medicaid Program now provides applications online. Applications are now available in Spanish and Vietnamese. //2009//***

The data serves as a comparative tool to other states and the associated outcomes.

The Louisiana State Systems Development Initiative (SSDI) program focuses on obtaining linked data, surveys, and registries. MCH epidemiologists will conduct studies and evaluations that will provide relevant information to program staff and policy makers in order to develop interventions that will help the state to meet national and state performance targets. SSDI program analysis and results will be disseminated at the state and local levels in the form of: 1) presentations to the State Perinatal Commission, the MCH Coalition, and internal and external meetings and conferences (e.g., MCH Epidemiology conference), 2) publications, such as the Louisiana State Medical Society Journal, Baby Talk Newsletter, and The Louisiana Morbidity Report, and 3) data and information on the state intranet and internet sites.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR	**Does your MCH program have**	**Does your MCH program**

SURVEYS	the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2009

Narrative:
The MCH Program employs its Epidemiology, Assessment and Evaluation (EAE) unit to provide relevant MCH data support in monitoring HSCIs. The EAE Core Group includes a CDC assignee MCH epidemiology team leader, a CSTE fellow, two SSDI staff, and two PRAMS staff, including a PRAMS coordinator and an assistant data manager. The Title V-MCH Director supervises the EAE unit.

The MCH/CSHCN epidemiology programs work with program coordinators, providers, and other stakeholders to share information obtained from the analysis of surveillance system data, linked data sets, and other MCH relevant surveys, and to seek program input on the policy implications of the findings. The MCH EAE unit works closely with internal partners at the Department of Health and Hospitals (DHH) to establish and improve linkages between vital records surveillance files and MCH related databases. The results are MCH-related surveys and registries and improved access to information to monitor health.

Louisiana has a State Systems Development Initiative in place to support this measure, HSCI 09A. SSDI staff and the EAE Unit provide the foundation, tools and structure to assure the MCH program access to policy and program relevant information.

Disparities in low birth weight and infant mortality continue to be major problems in Louisiana.

The Louisiana SSDI program focuses on increasing the data/epidemiologic capacity of Louisiana's MCH and CSHCN programs to address the problems mentioned above. The main goals of the project are to: (1) improve the data linkages, analyses, and dissemination utilizing birth records linked with infant death records, Medicaid eligibility files, WIC eligibility files, newborn screening data, Pregnancy Risk Assessment Monitoring System (PRAMS) data, Louisiana hospital inpatient discharge data, and birth defects surveillance data; and (2) establish to access to and analyze data of Caring Community Youth Survey (CCYS).

From the linked data, surveys, and registries, MCH epidemiologists conduct studies and evaluations that provide relevant information to program staff and policy makers in order to develop interventions that will help the state to meet national and state performance targets. The SSDI program is responsible for maintaining all MCH related data obtained through these various programs and assuring that the MCH program has access to the most recent data available for each data source.

Access to the CCYS data was just granted in June 2007 and data will be made available to MCH from this point forward. The new availability of these bi-annually collected data provides new opportunities to gain better insight into the behavior of Louisiana children in the 6th, 8th, 10th, and 12th grades.

SSDI program and EAE unit analyses and results are disseminated at the state and local levels in the form of: 1) presentations to the State Perinatal Commission, the MCH Coalition, and internal and external meetings and conferences (e.g., MCH EPI conference), 2) publications, such as peer reviewed journals, the Louisiana State Medical Society Journal, Baby Talk Newsletter, and The Louisiana Morbidity Report, and 3) data and information on the state intranet and internet sites.

/2009/ Staffing changes in 2008 included the graduation of the CSTE fellow in August, 2007 and resignation of the PRAMS coordinator and SSDI data manager in January, 2008. Although Louisiana was approved to host a new CSTE fellow, no match was made. A new PRAMS coordinator begins in June, and the SSDI position should be filled by August, 2008. The EAE unit will host a 2008 Summer intern through the Graduate Student Intern Program to work on MCH program evaluation.

Critical data collection/management responsibilities of these positions have remained covered through temporary redirection of remaining staff priorities and supplemental capacity from temporary contract staff and graduate students. Full analytic capacity will resume when new PRAMS and SSDI staff are in place.

Vital records 2005 data were unavailable until May, 2008, delaying analytic and translation activities for 2005, however new analyses of prior data continues. The EAE unit participated in a CDC-sponsored PRAMS course, resulting in a report on Louisiana preterm birth. Updated data linkages remain on schedule through SSDI. New analyses from linked vital records-hospital discharge data are nearly complete. CSHS birth defects surveillance completed its first full year of data collection; SSDI staff linked the data to birth records. Two abstracts based on CCYS data analyses were submitted to a conference. When the 2005 MCH indicator analyses are complete, new dissemination activities of all results will be scheduled with key stakeholders. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS	Does your MCH program have direct access to the state YRBS database for

	survey? (Select 1 - 3)	analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	2	No
Caring Community Youth Survey (CCYS)	3	Yes

Notes - 2009

Narrative:
Because the response rate of the Louisiana YRBS over the last several years has been inadequate, MCH will continue using tobacco use data obtained in the Communities that Care Youth Survey (CCYS). This survey is conducted by the Office of Addictive Disorders/DHH every two years and provides parish specific data on a number of adolescent risk behaviors, including tobacco use. According to the 2006 Communities that Care Youth Survey the percent of adolescents in grades 8 through 12 who reported using a tobacco product in the past month was 20.5%, down from 23.7% in 2004. Nationally, 23% of students reported current tobacco use in 2005.

As a public health measure to address tobacco use, the Adolescent School Health Program includes tobacco use as a core sentinel condition in their continuous quality improvement (CQI) program. Each SBHC is required to undergo a rigorous on-site CQI review. During the review, charts are audited randomly and evaluated on whether the provider asks the student about tobacco use and provides appropriate prevention and/or cessation counseling. ***/2009/ During 2007-08, 7 SBHC sites underwent review. //2009//*** In addition, many of the SBHC staff provide tobacco prevention programs at their schools. In addition, OPH has a Tobacco Control Program that has many initiatives underway to decrease tobacco use, including efforts to change environmental policies. The Tobacco Program is not funded with MCH dollars.

This Health Systems Capacity Indicator serves as a monitoring tool that will help Louisiana focus its resources on continued efforts to bring down the percent of adolescents who use tobacco products. By reducing the proportion of adolescents and young adults who use tobacco products, Louisiana can prevent the resultant morbidity and mortality of this risk behavior.

IV. Priorities, Performance and Program Activities

A. Background and Overview

Louisiana, like most of the Southeastern states, differs from the rest of the Nation in terms of its demographic profile and socioeconomic status. African-American births comprise 41% of total births black compared with 15% nationally. Because of this, the higher low and very low birth weight rates of black infants have a disproportionate effect on our infant mortality rate. Louisiana has one of the Nation's highest overall poverty rates and ranks 49th for child poverty. It ranks 50th for the rate of families headed by a single parent. It is a predominantly rural state with a low per capita income and also low literacy levels. These factors coupled with budget shortages experienced by the State present challenges to the Title V Program in achieving the goals of decreasing mortality and morbidity in the MCH population and assuring access to needed services. /2007/New challenges resulting from the hurricanes' impact on the state's infrastructures will impact the MCH Program's ability to deliver Title V services. //2007// ***/2009/ Louisiana Title V Program still faces such challenges as a high percentage of African American births (40% compared to 15% nationally) which affects infant mortality rates; second highest rates in the nation for infant mortality, low birth weight babies, child poverty, and children in single-parent families (ranked 49th, 2008 Kids Count); and access to care. //2009//***

/2007/ Program activities and assigned resources are now based on the following set of priorities, which were derived from the 2005 statewide MCH Needs Assessment: 1) Decrease infant mortality and morbidity in collaboration with regional coalitions 2) Decrease intentional and unintentional injuries in the MCH populations; 3) Address barriers, including Medicaid provider availability and lack of transportation, to assure access to quality health care for the MCH populations; 4) Address the mental health needs of the MCH populations; 5) Address the substance abuse related needs of the MCH populations through prevention and early intervention, screening, and referral; 6) Promote comprehensive systems of care and seamless transition to adult services for the CSHCN; 7) Promote pre-and inter-conception health care including family planning and folic acid education; 8) Address the oral health needs of the MCH populations; 9) Address healthy nutrition, proper prenatal weight gain, breastfeeding, and physical activity; 10) Obtain and utilize reliable evidence to: a) identify preventable causes of maternal, child and adolescent mortality and morbidity; b) develop preventive public health campaigns targeting high risk populations; and c) perform process and outcome evaluation.

/2009/ Final 2007 data showed improvements in licensed daycare centers with health consultant contact (SPM#10); children with special health care needs age 0-18 yrs. whose families have adequate insurance (NPM#4) and whose families report organized community-based service systems (NPM#5). No improvements were in CSHS patients with follow-up case management visits from nurse, social worker, nutritionist (SPM#4). //2009//

/2008/ Of the few performance measures with finalized 2006 data, an improvement was seen from 2005 to 2006 in the percent of CSHS patients with case management (follow-up visits) from a nurse, social worker, or nutritionist (SPM #4). An improvement was not seen in the percent of licensed daycare centers with a health consultant contact (SPM #10), which is primarily due to the loss of 426 child care centers due to Hurricanes Katrina and Rita and a loss of 61 child care health consultants.//2008// ***/2009/ Final 2006 data showed improvements in all children/adolescents enrolled in LA. public schools with access to SBHC services (SPM #1); infants receiving WIC in Public Health Units, screened with LA. Risk Assessment - Infant version (SPM #6); children with special health care needs 0-18 yrs. whose families partner in decision making/satisfied with services received (NPM#2); and youth with special health care needs who received services necessary to transition to adult life (NPM#6). No improvements were in newborns screened for hearing before discharge (NPM#12); children with no health insurance (NPM#13); and 19-35 mo. olds with full schedule of age appropriate MMR, DTP, H. Flu, and Hep. B) immunizations (NPM#7). The***

rate of abused/neglected children under 18 (SPM#3) was unchanged. //2009//

Of the few performance measures with finalized 2005 data, improvements were seen from 2004 to 2005 in NPM#1, follow-ups of positive newborn screens (increased to 100%); SPM#4, percent of CSHS patients with case management; and SPM#10, percent of licensed daycare centers with a health consultant contact. Improvements were not seen in SPM#1, percent of all children and adolescents enrolled in public schools with access to school-based health centers, and SPM#2, percent of women who received family planning services. One major contributing factor to the decreases in these measures is Hurricane Katrina, which resulted in the loss of SBHCs and the Women's Clinic in New Orleans. Also, statewide gaps in family planning services resulted from temporary suspension of services in the state's public health unit and/or delays in resuming services because of staff reassignment to emergency response duties. /2008/ Additional performance measures now have finalized 2005 data. Though improvement was not seen in NPM#16, the rate of suicide deaths aged 15 through 19, improvements were seen from 2004 to 2005 in NPM#10, rate of deaths to children under 15 years from motor vehicle crashes; NPM#12, percentage of newborns screened for hearing before hospital discharge; and SPM#10, percent of licensed day care centers with a health consultant contact.//2008//

/2009/ Final 2005 data showed improvements in deaths to children 14 yrs. and younger from motor vehicle crashes (NPM#10) and infants born to pregnant women with prenatal care beginning in the first trimester (NPM#18). No improvements were in SIDS infant deaths (SPM#8) and 19-35 mo. olds with full schedule of age appropriate MMR, DTP, H. Flu, and Hep. B immunizations (NPM#7). //2009//

However, from 2001 to 2004, there were improvements in the following performance measures: NPM#1, follow-ups of positive newborn screens; NPM#7, completely immunized children through age; NPM#8, teen birth rate; NPM#11, moms breastfeeding at discharge (2001-2003) NPM#12, newborns hearing screens; NPM#13, uninsured children; NPM#18, infants born to women with 1st trimester prenatal care; SPM#1, percent of all children and adolescents enrolled in public schools with access to school-based health centers; SPM#2, percent of women in need of and received family planning services; SPM#4, percent of CSHS patients with case management; SPM#7, percent of women who use alcohol during pregnancy (data through 2003), SPM#10, percent of licensed day care centers with a health consultant contact.

Performance measures which have not improved from 2001-2004 are: NPM#10, MVA fatalities of children under 15 years (increased); NPM#16, suicides among youths 15-19 (increased); NPM#17, very low birth weight infants delivered at facilities (increased); SPM#3, rate of children under18 abused or neglected (increased); SPM#5, percent of children (2-5) on WIC > 95th percentile weight for height (increased); SPM#8, rate of infant deaths due to Sudden Infant Death Syndrome (increased through 2003). There was no additional data to change in the National Performance Measures related to CSHS (NPM #2 - 6) or the percent of third grade children who receive protective sealants (NPM #9).//2007//

We feel confident that the approaches we have initiated to address the Priority Needs from the 2005 Needs Assessment and the operational plan we have developed to address the priority needs developed in the current needs assessment will have the positive outcomes we seek and ultimately will improve the the National Outcome Measures.

B. State Priorities

Priority Need 1: Decrease infant mortality and morbidity in collaboration with regional coalitions comprised of public and private health and social service providers.

Related Performance Measures (PM): National Performance Measures (NPM) 8, 15, 17, 18 and State Performance Measures (SPM) 7, 8 and 9

MCH funds community-based outreach, case management and home visiting programs in areas with limited access. This includes funding for family planning. In addition, MCH administers public information and media campaigns to reduce infant mortality promoting early prenatal care and healthy behaviors, and SIDS risk reduction. Communication is population-based and includes multi-media presentation and direct presentations (speeches, health fairs). MCH assists parish and regional MCH and public health leaders to address infant mortality through data analysis, technical assistance and funding of interventions. MCH funds Infant Mortality Reduction coordinators in each of the 9 regions to assure the infrastructure and capacity is in place to address this problem. In order to gather more detailed information on perinatal deaths, OPH has initiated the development of Fetal-Infant Mortality Reviews (FIMR) in all regions. The MCH Director and the Maternal Health Medical Director serve on the state Perinatal Commission which issues the state perinatal guidelines.

To reduce mortality due to congenital anomalies and birth defects, the Birth Defects Monitoring Network performs surveillance in the major birthing areas. The program also collaborates with the March of Dimes in prevention activities. /2008/The program increased active surveillance from 40 to 48% of births.//2008// ***/2009/ The program developed a resource guide for parents of infants in the birth defects registry to increase access to treatment and early intervention. Surveillance increased to approximately 57% of births. //2009//***

Priority Need 2: Decrease intentional and unintentional injuries in the maternal, child, adolescent, and children with special health care needs populations.

Related PMs: NPM 10, 16; SPM 3, 6

The MCH funds the SAFE KIDS program, a comprehensive injury prevention program that organizes local chapters, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, childproofing homes, bicycle helmet use, and sports injury prevention. MCH has established Regional MCH Injury Prevention Coordinators who work to decrease unintentional injuries in children in each of the 9 regions. MCH funds suicide awareness and prevention for school personnel and has collaborated with the Office of Mental Health on a grant to expand these trainings. The (NFP) Family Partnership and Best Start programs address primary prevention of family violence. The use of the Louisiana Risk Assessment in WIC clinics has increased the screening for domestic violence. The Prevent Abuse and Neglect through Dental Awareness program distributes materials on recognizing and reporting signs of child abuse and neglect to all dentists and hygienists. The Child Death Review Panel reviews all unexpected deaths in children under the age of 15. The MCH Program currently staffs a full time position for the Child Death Review Panel. The network of 160 Child Care Health Consultants provide health and safety training for child care providers.

CSHS provided leadership and funding for a special project to address prevention of secondary disabilities in CSHCN from birth to age 5 and has collaborated in a national grant to train parents of CSHCN to promote healthy activities and nutrition in this population. CSHS conducted a survey of families with CSHCN prior to Hurricane Katrina in a joint project with Bioterrorism Program. Families were provided information on making plans for evacuation and special considerations for CSHCN. Another survey will be performed in conjunction with CDC grant with Federation for Families for after-action information and problems encountered. /2008/ The AAP Emergency Form is used in CSHS clinics to help prepare families of CSHCN for evacuation.//2008// ***/2009/ Training for coroners, death scene investigators, injury prevention health educators, and other health professionals attended an MCH sponsored conference on Death Scene Investigation, Child Death Review and Injury //2009//***Prevention.

Priority Need 3: Assure access to quality health care for the maternal, child, adolescent, and children with special health care needs populations, addressing barriers including Medicaid provider availability and lack of transportation.

Related PMs: NPM 1, 3, 4, 5, 6, 7, 13; SPM 1, 2, 4

The CSHS Program will implement a care coordination model. It will include medical home coordination as a component of the plan of care and promotion of health strategies, including primary, secondary and tertiary prevention of disabilities. Parent participation in the program assures that the CSHS Program is family-centered and advocacy-focused. CSHS has had parent participation for over 14 years. Parent Liaisons attend CSHS clinics to offer emotional support and resources to families of CSHCN. Parent input into program policy and procedures occurs with 3 statewide parent coordinators who have collaborated with staff in the development of the Care Coordination model, continuous Quality Improvement, Universal Newborn Hearing Screening Systems, and the Medical Home project. /2008/ CSHS has piloted the Care Coordination program in Region I in the aftermath of Katrina.//2008// ***/2009/ CSHS is conducting a second care coordination pilot, with plans for expansion. CSHS collaborated with Families Helping Families to provide transportation for families in Region VI (Alexandria) to medical appointments outside of the region. //2009//*** The Part C program, Early Steps, also provides Family Service coordination for eligible children from birth to age 3. CSHS will incorporate support for wrap-around services to assist families overcome barriers to care such as transportation. Funds shifted from direct services will be used to provide these enabling services. In addition, families will be trained and encouraged to be better consumers of services so that quality health care will be easily accessed. /2008/Early Steps was moved to the Office for Citizens with Developmental Disabilities July 1, 2007.//2008//

MCH funds prenatal, family planning and preventive/primary care in areas with limited access to such services. Adolescent School Based Clinics (ASBC) continue to reach this underserved population and additional funding from the Kellogg Foundation and the state will add clinics in hurricane-ravaged New Orleans. Additional newborn screening tests have been added to the battery of genetic and metabolic testing. MCH funds immunization services statewide. MCH works closely with Medicaid and the Robert Wood Johnson funded Covering Kids and Families outreach programs, resulting in significant decreases in uninsured pregnant women and children. /2008/ Newborn screening tests have been added to be in line with national standards. A Family Planning Waiver has been implemented in Louisiana. DHH received state funding to continue the work of the Robert Wood Johnson grant which ended. Undocumented pregnant women can receive Medicaid coverage effective May 2007.//2008//

Priority Need 4: Address the mental health needs of the maternal, child, adolescent, and children with special health care needs populations, through prevention and early intervention, screening, referral, and where appropriate, treatment.

Related PMs: NPM 3, 5, 6; SPM 1, 3, 4, 6
/2008/ MCH received a Perinatal Depression grant allowing the hiring of mental health staff serving women in the New Orleans region.//2008// MCH funds the Nurse Family Partnership, a psycho-social intervention for first time mothers of low socioeconomic status, in all regions of the State. Mental health services are provided in all ASBCs. MCH collaborates with the Office of Mental Health (OMH) to provide mental health support and services to the Program. MCH and CSHS collaborate with the OMH Early Childhood Supports and Services (ECSS) program that provides mental health services to children from birth to age 5. MCH developed the Louisiana Risk Assessment (LRA) tool to screen families for mental health risk factors and uses this for referral to ECSS, Best Start and other interventions.

MCH has developed a new parenting newsletter. The series emphasizes developing healthy infant caregiver relationships, healthy social and emotional development, parent and parenting issues, and mental health concerns. Public health nurses assist child protection workers in investigating suspected cases of medical neglect, malnutrition and failure to thrive, through an interagency agreement with Office of Community Services. A 30 hour Infant Mental Health (IMF) Educational Series was developed. The series emphasizes attachment theory and current knowledge of infant social and emotional development. This IMH training is provided to public

health staff, including CSHS staff. /2008/ Eight CSHS nurses are currently receiving mental health training to aid in their identification of mental health concerns in young children.//2008//

CSHS is developing parent training modules to address issues experienced by families of CSHCN in lower socio-economic populations. CSHS has begun to see an increased need for mental health services for families affected by recent disasters. Limited state resources to address these needs are being recognized, however funding has not been made available for services.

Priority Need 5: Address the substance abuse related needs of the maternal and adolescent population, through prevention and early intervention, screening, and referral. Assure early identification and referral of substance abuse, domestic violence and child abuse and neglect.

Related PMs: NPM 15; SPM 6, 7, 9

A risk assessment is conducted on patients receiving comprehensive prenatal care in the parish health units, and includes questions about substance abuse and domestic violence. Referrals are made to local substance abuse treatment facilities and battered women shelters. The LRA tool focusing on psychosocial risk factors, specifically substance use, domestic violence, financial/social service needs and mental health has been disseminated for use along with training for brief intervention. The MCH child health record is used to identify infants and children at risk for child abuse and neglect by looking at factors, such as parental substance use. Contracts with the state Office of Addictive Disorders provides pregnancy testing for women in treatment for substance abuse, counselors to provide services in an MCH funded prenatal clinic in Monroe, and for the development of a statewide system of services for the perinatal population. MCH targets smoking cessation services for perinatal populations through a contract with the Louisiana Public Health Institute to work with prenatal providers and to conduct a media campaign. CSHS, through Early Steps, has entered into an agreement with the Office of Community Services to provide for a mandatory referral of all children, birth to age 3, with substantiated abuse or neglect findings to the Part C System. /2008/ The state Office of Addictive Disorders, MCH, Medicaid, Office of Mental Health and the National Training Institute have implemented a comprehensive intervention for substance abusing pregnant and postpartum women in 4 areas of the state.//2008//

Priority Need 6: Promote comprehensive systems of care and seamless transition to adult services for the Children with Special Health Care Needs population by providing care coordination.

Related PMs: NPM 2, 3, 4, 5, 6; SPM 4

CSHS provides subspecialty health care and care coordination services in 9 regional subspecialty clinics. The CSHS Medical Home project specifically targets access and utilization of primary care by families of CSHCN. /2008/ CSHS funds 2 care coordinators in model medical homes. Recent Medical Home Index Surveys and Family Satisfaction Surveys document the effectiveness of the care coordinators.//2008// ***/2009/ These results were presented at a state Medical Home Summit. CSHS is working with Medicaid to include care coordination into plans for a redesigned healthcare system based on medical home. CSHS will continue to place care coordinators in key Medical Homes. //2009//***

The CSHS Program has taken a leadership role in the Medical Home Project, assuring that all children have a medical home. The Community Care Program provides physician primary care case management for Medicaid clients. All children in CSHS medical clinics are screened for primary health care coverage, and families are referred to primary care providers when the child has none. CSHS is working to enhance opportunities for increased access to care for CSHCN that have resulted in the aftermath of recent disasters. Pediatric health care providers who accept Medicaid have expanded services to meet needs of shifting population base.

CSHS has implemented a transition project that includes all 15 and 16 year old children seen in clinics. Staff and Parent Liaisons discuss transition issues with families and refer for additional resources. /2008/ The transition project was expanded to include children 14-17 years of age.//2008//

Priority Need 7: Promote pre-conceptional and inter-conceptional health care including family planning and folic acid education.

Related PMs: NPM 8; SPM 2

MCH provides funding for the operation of the Family Planning program and provided leadership and technical assistance for the development of the Family Planning Medicaid Waiver that was recently approved. The NFP program has a strong focus on the inter-conceptional health of its clients, addressing physical health issues including postpartum care and family planning; mental health issues including depression and domestic violence; and social health issues including educational and vocational attainment. ***/2009/ MCH sponsored a conference on pre and inter-conceptional health with 130 health professionals attending. MCH Bureau provided technical assistance funding for Michael Lu, M.D., a noted expert, as the featured speaker. MCH will provide funding for folic acid to be distributed to OPH Family Planning patients beginning July 1, 2008. MCH is conducting the evaluation for the Family Planning Medicaid Waiver program. //2009//***

Priority Need 8: Address the oral health needs of the maternal, child, adolescent, and children with special health care needs populations

Related PMs: NPM 9

CSHS funds a Dental Clinic for CSHCN in the New Orleans area. Services are provided by LSU School of Dentistry and are designed to be readily accessible to this population, known to have barriers to accessing regular dental care. This project also enhances training for dental students in providing care to CSHCN. CSHS provides assistance for non-Medicaid eligible children to receive routine dental services through the private sector. The Oral Health Program (OHP), in conjunction with the Fluoridation Advisory Board of Louisiana, works with non-fluoridated communities. The OHP provides funding and technical assistance for the fluoridation projects. The OHP assesses the oral health needs of children and adolescents. School-based sealant initiatives are being implemented in 6 parishes. In addition, a sealant initiative is being implemented in the trailer communities and schools serving hurricane evacuees. The OHP promotes the Medicaid covered dental services for pregnant women with periodontal disease to pregnant women, prenatal providers, and dentists. /2008/ The Oral Health Program was awarded an infrastructure grant from HRSA.//2008// ***/2009/ Two additional staff were hired in the Oral Health Program focusing on fluoridation and school-based sealant expansion, which expanded fluoridation services to another community and sealant services to 9 parishes. //2009//***

Priority Need 9: Improve the health of the maternal, child, adolescent, and children with special health care needs populations, addressing healthy nutrition, proper prenatal weight gain, breastfeeding, and physical activity.

Related PMs: NPM 11, 14

Parish health units provide all pregnant women with extensive counseling and education on healthy nutrition, breastfeeding and proper weight gain. Families of children receiving WIC services receive counseling and educational materials. MCH has initiated a breastfeeding promotion program entitled The Gift. This intervention targets delivery hospitals and seeks to

certify the hospitals as a "breastfeeding-friendly" once a list of requirements are met. Breastfeeding coordinators in each parish health unit and peer educators promote breastfeeding among the WIC population.

CSHS is participating in a CDC grant with Tufts University and the Federation of Families to prevent additional disabilities in CSHCN. Families have participated in focus groups to determine issues with the most relevance to this population and nutrition and exercise is a focus. /2008/ A nutritionist was hired, enabling CSHS regional nutritionists to have central office direction in meeting the unique nutritional needs of CSHCN.//2008//

Priority Need 10: Obtain and utilize reliable evidence to: a) identify preventable causes of maternal, child and adolescent mortality and morbidity; b) develop preventive public health campaigns targeting high risk populations; and c) perform process and outcome evaluation

Related PMs: The program supports all of the Performance Measures through this priority need but most specifically NPM 8, 10, 11, 15, 16, 18; SPM 7, 8, 9, 10

MCH has been successful at linking birth records with Medicaid, WIC, newborn screening, and PRAMS data to assess maternal, infant, and child mortality, morbidity, and contributing risk factors. Data from Louisiana's hospital discharge data base and birth defects registry adds to the information MCH uses to determine which interventions, geographic areas, or sub-populations need are priorities. The MCH Epidemiology, Assessment, and Evaluation Section conducts multi-level analyses, disseminates MCH data to national, state, and local stakeholders, and informs decision-making among the MCH management team and other public health staff including state Medicaid, WIC, Family Planning, Sexually Transmitted Diseases, Lead Poisoning Prevention, Oral Health, and Newborn Screening programs. MCH funded Injury Prevention Coordinators in each region utilize injury data to determine priorities for intervention. The SIDS and Partners for Healthy Babies media campaigns use state level quantitative data along with focus groups and sentinel site surveys to develop messages and evaluate impact of the campaigns. Distribution of region-specific data at the annual meeting of the 9 Regional Infant Mortality Reduction Initiatives allows local leaders to understand the health status and trends of their maternal and child population and conduct needs assessments and strategic planning.

The Birth Defects Monitoring Network performs surveillance in the major birthing areas of the state. When data collection reaches reportable levels, prevention activities will be targeted to those high risk areas. This program recently collaborated with the Infectious Epidemiology section and the Region VI OPH office in an investigation of anencephaly cases in a community. Scientific methods were used to investigate this possible cluster and results were reported to the Regional Office and the community. ***/2009/ The Birth Defects Monitoring Network is collaborating with MCH epidemiology to determine if the possible cause of increased gastroschisis cases in Region IV. //2009//***

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	95	95	95	99	99
Annual Indicator	95.2	94.2	96.0	99.1	97.9
Numerator	120	114	120	116	137
Denominator	126	121	125	117	140
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	99	100	100	100	100

Notes - 2007
Data is for calendar year.

Notes - 2006
Data is for calendar year.

Notes - 2005
Data is for calendar year.

a. Last Year's Accomplishments
The adoption of the complete American College of Medical Genetics recommended core newborn screening panel of 29 disorders occurred with the implementation of screening for cystic on July 1, 2007. The other metabolic disorders detected through tandem mass spectrometry had been added in 2004 and along with congenital adrenal hyperplasia in 2006.

Population Based Services
Table 1 indicates the number of infants detected with the diseases included in the newborn screening battery from 2004 through 2007. The table reflects the success of the newborn screening expansion as well as the effective collaboration with the University of Iowa Public Health Hygienic Lab that covered the testing during the early post Hurricane Katrina period.

The Genetics Section ensures that greater than 95% of newborns are screened for all the diseases on the official battery by providing education to medical providers on the legislation and rule mandating screening, and by only allowing Office of Public Health (OPH) approved laboratories to perform the tests on newborns. The project of matching newborn screening records with birth records was conducted in 2006 with 2004 data and in 2007 using 2005 data.

Direct Services
Genetics Program continued to contract with medical geneticists to conduct regional genetics clinics at ten sites reaching 500 families, ensuring early detection and initiation into specialized care.

Enabling Services
Contracts were continued with Sickle Cell Foundations in 7 regions to provide patient assistance to families affected by sickle cell disease.

Infrastructure Building Services
After Hurricane Katrina, the laboratory data management system was modified to handle the data of the newborn screening tests performed by the University of Iowa Hygienic Laboratory and then modified again once the Office of Public Health Lab resumed testing on November 12, 2007. Other areas of infrastructure building include the hiring of two follow-up staff and the follow-up coverage for after hours, weekends and holidays.

The Louisiana Newborn Screening Advisory Committee (LANSAC) continued to meet on the adoption of the American College of Medical Genetics' core panel and newborn screening policy issues, such as policy 24 vs. 48 hour cut off for repeating the screen and the policy of rescreening post blood transfusion. Also, the ad hoc Metabolic Group continued to meet to address the high

rate of suspect positive results identified through tandem mass spectrormetry.

An attachment is included in this section.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct universal newborn screening and follow-up for 29 conditions.			X	
2. Conduct training sessions at hospitals to reduce unsatisfactory screening specimens.				X
3. Conduct regional genetics clinics at 10 sites staffed by a medical geneticist.	X			
4. Provide clinic-based wrap-around services by contracted sickle cell foundation staff.		X		
5. Educate adolescent PKU girls and high risk maternity staff on fetal effects of maternal PKU.		X		X
6. Provide an educational program for sickle cell patients and families.		X		
7. Provide an educational program for medical providers on metabolic diseases detected through tandem mass spectrometry.				X
8. Develop protocols for NICU staff for timing of rescreening.				X
9. Enhance program website as medical providers begin to use it as the source for current information on NBS.				X
10.				

b. Current Activities

Direct Services and Enabling Services

Genetics Program continues to conduct regional genetics clinics for evaluation and counseling. Since the expansion of the newborn screening panel, these clinics have become important for referral of metabolic patients. Contracts are continued for regional sickle cell foundations.

Population-Based Services

The core panel recommended by the American College of Medical Genetics was adopted. The last of the diseases to be added to the panel was cystic fibrosis on July 1, 2007.

Infrastructure Building Services

Genetics Program met a number of times with the Tulane Human Genetics Program to assist on development of a HRSA grant project entitled the Enhanced Genetic Services and Newborn Screening Collaborative in Region 3. The overall goal of this project is to utilize the unique established regional genetics infrastructure provided by the Southeastern regional Genetics Group, Inc. (SERGG, Inc.) for developing a regional approach to address the misdistribution of genetic resources and promote the rapid translation of genomic medicine into public health and health care services. This group has been very effective in addressing emergency preparedness issues and forming a laboratory work group to assist states in adopting the ACMG core panel.

The Louisiana Sickle Cell Medical Council will continue to meet to develop a plan for transitional and adult care, and to address improvements in the current regional pediatric sickle cell system.

c. Plan for the Coming Year

Objective: Increase to 96% the percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g.

phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.

Direct and Enabling Services
The Genetics Section will ensure the provision of specialized medical and nutritional management for 100% of affected infants identified through newborn screening pursuant to the adoption of tandem mass spectrometry. Genetics will continue to contract with medical schools to cover patients identified through the expanded metabolic screening.

Population-Based Services
The Genetics Section will review and evaluate the outcome of the adoption of the ACMG core panel.

Infrastructure Building Services
The Genetics Section will convene the Newborn Screening Advisory Committee to review the data from over a year of testing the expanded panel and addressing emerging issues in newborn screening. Increasing the availability of screening result data of patients for authorized medical providers will be evaluated and considered, such as inclusion of newborn screening specific data fields on the LINK System. Consideration will continue for consolidating the newborn hearing infrastructure with that of the newborn heel stick system. Website enhancements will be made over the next year to include a parent section and a page on fetal effects of maternal PKU

Improving the knowledge level of medical providers on the following newborn screening topics will be addressed through professional education:

- expanded screening and confirmatory testing of newborns with positive metabolic results
- screening protocols for transfused infants and infants on Total Parenteral Nutrition
- blood specimen collection
- fetal effects of maternal PKU
- transitional care for sickle cell patients

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	60	60	60	60	62
Annual Indicator	55.2	55.2	55.2	55.2	62.2
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	65	65	65	65	65

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The CSHCN Survey for 2005/2006 shows 62.2% of families of CSHCN in Louisiana partner in decision--making at all levels and are satisfied with the services they received. This is an increase from the last CSHCN Survey of 57.5% and is above the national average for this measure. In 2002 Louisiana was below the national average. The 2005/2006 annual performance objective was 60%.

Direct and Enabling Services
CSHS strived to provide services to empower families to become active partners in decision-making for their children. The Parent Liaisons (PLs) provided parent support services to families of CSHCN attending CSHS clinics in all 9 regions of the state. PLs gave families practical advice on interacting with professional staff and becoming active in decision making issues for their children. PLs developed resource manuals of frequently needed information that was available to families at clinic. When requested information was not readily available, the PLs obtained the information and mailed to families after clinic. PLs gave out their phone numbers and were available by phone to respond to family's requests for information.

Population Based Services
In conjunction with Families Helping Families (FHF), the PLs provided community--based trainings for families served by CSHS, as well as other families of CSHCN. These trainings provided information related to CSHCN, such as transition into adult services, waiver services, keeping medical records, people first language, becoming better consumers of services, and staying organized. CSHS provided stipends to families to attend some training. PLs were trained on how to work with families who have different cultural backgrounds or beliefs, thereby lessoning barriers to services. Some of the PLs provided community--based outreach to non-English speaking families, including Spanish, Vietnamese and Cajun French. The Parent Trainer produced a quarterly newsletter for families (Family Matters) that gave information on community resources, upcoming events, and other topics of interest. All PLs had the opportunity to write a section of the newsletter. The CSHS website was updated and included links to many resource sites of benefit for families, including state and local agencies and organizations.

Infrastructure Building
CSHS employed a statewide Parent Consultant and Parent Trainer to facilitate inclusion of parent involvement at the state policy making level. The Parent Consultant was instrumental in re-evaluation and revision of the care coordination program during this period. Both Statewide Parents participated on the planning committee of the annual CSHS Conference. CSHS employed 12 regional PLs to work in the CSHS clinics to facilitate inclusion of parents at the local level, as well as to participate in local policy issues. PLs included 4 African Americans, 2 Hispanic, 1 Vietnamese, and 1 Cajun French. The Parent Trainer developed programs to provide orientation and quarterly trainings for all regional PLs. PLs had input into the topic of the trainings by ranking interest from a list of issues related to CSHCN. Training topics included: cultural diversity, effective ways to teach families, difference and sensitivity training, voting rights, housing laws aimed at persons who have disabilities and/or may be subject to discrimination, and many other topics. All PLs were trained on Q.U.E.S.T (Quality, Understanding, Educational, Supportive, and Team). The Q.U.E.S.T program was developed by the Louisiana Parent Consultant and Parent Trainer in 2006 and is geared to families who have experienced multiple barriers to receiving services. Some activities in the training included role play to illustrate family perception

of dealing with health care providers. The emphasis was for staff to think about ways to make sure that families understand and participate in planning for their CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide funding for CSHS staff and Parent Liaisons in all CSHS offices.				X
2. Employ parents of different ethnicities.	X	X	X	X
3. Provide direct support services to all families attending CSHS clinics.	X	X	X	
4. Provide quarterly trainings for PL staff.			X	
5. Provide trainings and workshops for families.			X	
6. Include parents in policy decision making at all levels.				X
7. Work with F2F HICs to coordinate services.		X		
8. Translate CSHS brochure into Spanish & Vietnamese.	X	X	X	
9. Provide information to parents of children listed on the Birth Defects Registry.	X	X	X	
10.				

b. Current Activities

Direct and Enabling Services

PLs continue to provide services to families of CSHCN in CSHS statewide. Ongoing updates are made to resource manuals.

Population Based Services

PLs began working with the Family 2 Family Health Information Centers (F2F HICS) to develop information for families of CSHCN. PLs can refer families to F2F HICs when additional information or service is needed. PLs conduct community based trainings based on needs/requests from families of CSHCN served in CSHS and their communities. The Family Matters newsletter is developed and distributed quarterly. A resource guide is being developed for families whose infants are entered into the birth defects registry.

Infrastructure Building Services

CSHS continues to employ the Statewide Parent Consultant, Parent Trainer and PLs in all regions of the state. All PLs participate in policy making decisions at the state and local levels. CSHS emphasizes family participation in trainings for both PLs as well as clinical staff. The Parent Consultant is on the planning committee for the annual CSHS conference. The Parent Trainer offered various trainings to PLs throughout the year on steps for starting local support groups. Q.U.E.S.T was placed on the National Family Voices Website in December 2007, in the tool box section, for parent download. To date there has been over 160 downloads for Q.U.E.S.T and over 500 web hits. All new staff in CSHS attended a 4 day training that included PL role in CSHS.

c. Plan for the Coming Year

Objective: To increase to 65% of children with special health care needs age 0- 18 whose families partner in decision making at all levels and are satisfied with the services they receive.

Direct and Enabling Services

PLs will work closely with the F2F HICs in their regions to coordinate resource information and services. CSHS will explore ways to translate the CSHS brochure and other information into

Spanish and Vietnamese. CSHS will continue to employ PLs of different ethnicities to assist in addressing the needs of an ethnically diverse client population.

Population Based Services
CSHS will work to enhance information for families that will assist them to be active partners in decision making. The Birth Defects Resource Guide will be mailed to parents whose infants are on the birth defects registry. PLs will have the resource manual available in clinics for handouts to families. PLs will continue to update resource manuals and all information that is given in clinic. This will ensure quality and accurate information for families. PLs will host trainings in their regions for families and provide information that will help them in making informed decisions concerning their CSHCN. Parent Consultants will continue to provide quarterly trainings for PLs to assure that they have quality updated information to share with families who utilize CSHS.

Infrastructure Building
CSHS will continue to update the CSHS website including PLs contact information and phone numbers. CSHS will continue to offer the Family Matters newsletter and place it on the website for download by families. PLs will continue to be provided ongoing training to enhance the services offered to families. CSHS will continue employ the Statewide Parent Consultants and regional PLs to assure that families partner in decision making at the local and state levels. Regional PLs will continue to offer support and information in workshops and support group meetings to families with CSHCN. During this year, the Parent Consultants will offer trainings on the following topics: ACT 378- The history of the parent movement in Louisiana for community and family supports; Adult Opportunities: As required by the Office of Citizens with Developmental Disabilities; Educational Changes: If and when 504 Modifications are signed into law; F2F HIC: Strategies for helping families develop a plan for their children's medical transition; Safety on the Job: How to stay safe, and safety in the work place; Public Speaking: Revisited with new staff; Telling your story: There is a time and a place to tell your story; and, Telling your story can be a powerful tool for understanding change.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	55	50	50	50	55
Annual Indicator	48.8	48.8	48.8	48.8	49.6
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	55	55	55	55	55

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
49.6% of CSHCN in Louisiana received care in a medical home (MH) according to the 2006 CSHCN survey versus 47.1% nationally. The goal was 50%. Louisiana moved from below the national average in 2001 (48.8% LA vs 52.6% US) to above the national average in 2006. According to our cluster analysis using CSHCN survey data, in the Louisiana cluster 85.9% of CSHCN received primary care from a doctor's office as opposed to 80.9% in other states. CSHCN in the Louisiana cluster had fewer problems obtaining referrals when needed (83.4% vs 78.4% in other states) and a higher percentage received CC (61.8% vs 58.9% in other states). More said they received CC from their doctor (77.2% vs 73.0% in other states) as opposed to other sources.

Direct and Enabling Services
CSHS subspecialty clinics continued in all areas of the state, with Transition Services for children age 14 to 17 and linkage of CSHCN with a primary care physician. 99% of children coming to CSHS clinics were linked with a primary healthcare physician (PCP) despite disruption of medical homes and exodus of physicians out of state. Consultation letters were dictated for the PCP after every CSHS subspecialty clinic. A match was made with the CSHS billing database and the Medicaid database to update addresses for CSHCN who were lost to follow-up after Katrina. It appears that most of the lost patients moved out of state. Overall CSHS clinic numbers have declined gradually, from 5360 in 2004 (pre-Katrina) to 4645 in 2007. 25% of physician contracts were terminated because of physician emigration from the state. New contracts were initiated for regions where other access to sub-specialty care did not exist. The Continuity of Operations Plan to provide for continued CSHS operations in the event of a disaster was re-written using lessons learned from Katrina. A statewide nurses training was held in September focusing on clinical skills needed for CSHS subspecialty clinics.

Population-based Services
The Care Coordination (CC) pilot in Region I CSHS clinic was suspended for revamping and conversion of the data base to a web-based Sequel format. Constant turnover of the CSHS staff in this region post-Katrina coupled with the poor return of clinic patients to the area made successful completion of this pilot difficult. A social worker advisory group was formed for revision and testing of the database. A two day conference for all CSHS staff on CC and transition services in CSHS clinics was held in September to prepare staff for increased CC and transition responsibilities. Care coordinators continued in two model MH clinics in Bogaloosa and in the LSU Pediatric Faculty Practice Clinic (Tigercare). In Tigercare quarterly MH meetings were held with all clinic staff to improve the "medical home-ness" of the clinic. Although the clinic was flooded and had to be rebuilt post-Katrina, the aggregate pre-storm data was retrieved. Therefore post-CC surveys were completed of families who had been in the clinic for at least three months post Katrina. Clinic staff were surveyed using the MH Index and 92 families of CSHCN coming to the clinic were surveyed using the Family Index. Surveys indicated significant ($p<<.05$) improvement in family satisfaction in 13 of 16 questions, and improved clinic MH criteria for CC and community outreach domains after CC and regular "MH" meetings were begun.

Infrastructure Building Services
Dr. Berry presented two talks on the Tigercare Medical Home (TMH) for health care professionals active in determining the state healthcare infrastructure post-Katrina. One was for the LA Healthcare Redesign Collaborative, assigned to develop the ideal healthcare model for the recovery areas post-Katrina based on the MH model. In the past two years all pediatric and

medicine-pediatric residents in both Tulane and LSU Medical Schools have been trained in the MH model during their development rotation, which is directed by Dr. Berry. LSU residents that have their outpatient experience in Tigercare practice in the model MH for their entire residency. Many of these residents will establish their own MH practices in LA based on the model learned in residency.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide subspecialty care in shortage areas.	X			
2. Link CSHCN in CSHS clinics to medical homes.		X		
3. Support transition services for adolescents.		X		
4. Identify health coverage for transitioning CF patients.		X		
5. Provide population based care coordination in CSHS clinics.			X	
6. Provide care coordinators to pediatric offices.			X	
7. Provide evidence for care coordination effectiveness to encourage Medicaid reimbursement; participation in state HCQF Medical Home Advisory Group.				X
8. Incorporate medical home model into LSU pediatric resident training.				X
9.				
10.				

b. Current Activities

Direct and Enabling Services

Transition services in CSHS clinics have expanded to include 14-18 year old YSHCN. The Transition Clinics for New Orleans and Baton Rouge were cancelled because the physician left the state. CSHS continues to identify contract physicians to address subspecialty shortages. A CSHS nutritionist was hired to supervise regional nutritionists and update polices.

Population-based Services

CC software revision to a web-based program is complete. The pilot will be conducted in New Orleans in June. The care coordinator in the Tigercare Pediatric Clinic is leaving the state and will be replaced. A second care coordinator continues in Bogalusa. CSHS brochures for patients and physicians were developed for marketing and education purposes. These are distributed to PCP's by regional staff.

Infrastructure Building Services

Results of the TMH surveys were presented to the state Health Care Quality Reform committee in February and to the MH Summit for 115 invited policy makers May 23. As a result, Dr. Berry received a commitment from the new director of Medicaid to begin reimbursement for CC activities to provide MH incentives to PCP's. CSHS met with Medicaid to identify coverage for cystic fibrosis (CF) patients in transition. Sources of coverage were identified for all CSHS CF patients over age 21. Barriers to enrollment were identified and addressed. All Tulane and LSU pediatric and medicine-pediatric residents are trained on MH.

c. Plan for the Coming Year

Objective: to increase to 55% the CSHCN who receive ongoing, comprehensive care within a medical home. (CSHCN survey 2010)

Direct and Enabling Services

CSHS will continue to identify subspecialty shortages throughout the state and contract with physicians to serve those areas and improve access to care. CSHCN coming to CSHS clinics will continue to be linked to medical homes, and consult letters sent to the PCP after every visit. Results of the CC pilot in Region I CSHS clinics will be presented at the CSHS conference in October as part of staff training for the new system. As the new CC pilot is replicated in other regions of the state, copies of each child's CC plan will be sent to the PCP with the sub-specialty consultation letter. Transition services will continue using life maps for CSHCN not yet receiving transition services through the new CC system. Revisions will continue on the CSHS nutrition manual and CSHS policy manual.

Population Based Services
The results of the CC pilot will be presented at the CSHS conference in October. The system will then be expanded to additional areas of the state with the hope of eventually becoming a population based tool for CC open to children not coming to CSHS for sub-specialty care. CSHS funded care coordinators will continue in two model MH clinics and a third will be added in a Spanish speaking LSU pediatric clinic. A state level supervisor will be added to provide training and assistance for care coordinators working in individual practices. When this supervisor and the third coordinator are in place, two additional practices will be added: a large Children's Hospital practice in Lafayette and the Tulane pediatric resident continuity clinic. Since the care coordinator in Tigercare has just announced she is leaving the state and staff turnover has continued to be a concern post-Katrina coupled with the prolonged contract process, it is anticipated that these goals will take two years to achieve. Ways to increase CC activities in PCP offices will continue to be explored.

Infrastructure Building Services
Dr. Berry is on the Advisory Board for the Health Care Quality Forum Medical Home Committee, which has adopted the NCQA Criteria for Patient Centered Medical Homes. CSHS will continue to remain involved in the committee's activities to implement MH incentives in Louisiana. CSHS will continue to work with Medicaid to increase reimbursement for CC and other MH activities. Patients who are aging out of CSHS clinics will continue to be linked with new Medicaid/ Medicare programs for continued coverage and access to care. CSHS believes that developing MH's in LA is one of the most effective ways to decrease health disparities, as demonstrated by the Commonwealth Fund.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	55	57	55	55	57
Annual Indicator	51.9	51.9	51.9	51.9	65.5
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	70	70	70	70	70

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The CSHCN Survey shows a 13.6% increase from 51.9% for the initial 2001 survey to 65.5% for the 2005/06 survey. Louisiana was below the national average for this indicator in 2001 and in 2005/06 is above the national average. The annual performance objective was 55%.

Direct Services
CSHS staff evaluated insurance coverage for all CYSHCN attending direct services clinics and worked with families to apply for insurance coverage as needed. Families were informed and counseled concerning eligibility requirements and changes for Medicaid programs (LaChip, LaHipp, Medicaid Purchase Plan). Staff assisted families who had private insurance with various issues pertaining to their individual policies.

Enabling Services
CSHS disseminated health insurance informational brochures (Medicaid, SSI) to families in CSHS clinics in English and Spanish. Staff assisted families to enroll in insurance programs which met their coverage needs. These brochures were also placed in CSHS clinic waiting rooms. Parent Liaisons in each of the CSHS clinics compiled a resource binder to inform staff, families and community stakeholders on resources, including insurance.

Population-Based Services
CSHS provided informational material at health fairs and other community events regarding CSHS services and Medicaid programs. The CSHS website included a link to Medicaid and SSI.

Infrastructure Building Services
CSHS staff worked with State Medicaid staff to implement a Medicaid community care waiver for CSHCN receiving Title V services, as required by Federal Law. This was previously a major obstacle due to issues related to identification of eligible children in the Medicaid database. CSHS Social Work Consultant disseminated information and trained staff and community stakeholders on changes in Medicaid program policy. Clinic staff worked with local Medicaid staff to become familiar with policy changes. Staff also worked with insurance providers to coordinate benefits. Audiologists were trained in Medicaid pre-authorization procedures for hearing aids.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Medicaid and State Insurance programs to assure coverage.			X	X
2. Inform families of available services and programs.		X		
3. Provide informational materials to families in the clinical setting.		X		
4. Work directly with families to link to services.	X			

5. Expand Care Coordination Services.	X	X		
6. Track and advocate for LA CSHCN with regards to the Health Care Redesign initiative.			X	X
7.				
8.				
9.				
10.				

b. Current Activities

Direct Services

CSHS staff works with all families in direct services clinics to enhance linkage to needed community resources, including adequate health insurance coverage.

Enabling Services

Medicaid information brochures are available in all public health clinics, in English and Spanish. Parent Liaison staff continues to work with families to provide resource information on health insurance.

Population-Based Services

CSHS Social Work Consultant disseminates information and trains staff and stakeholders on changes in program policy. The Medicaid contact person and CSHS Social Work Consultant have ensured all Medicaid eligible Cystic Fibrosis patients over age 19 are adequately covered. Clinic staff supports families' enrollment in programs which meet coverage needs. The CSHS website lists health care coverage information, including Medicaid programs.

Infrastructure Building Services

CSHS established a primary contact person in the Medicaid office who expedites applications and streamlines solutions where coverage barriers exist for the population. The contact person alerts staff of changes in policy and programs. CSHS works with all providers to expedite paperwork so sufficient and continuous health care coverage is received.

c. Plan for the Coming Year

Objective: 70% of families of children with special health care needs ages 0-18 will report that they have public or private insurance that is adequate to meet their needs. (CSHCN survey 2010)

Direct Services

CSHS staff will continue to provide care coordination in direct clinic services which includes linking families to resources that provide health insurance coverage.

Enabling Services

CSHS staff will provide health insurance informational brochures to families, as well as other resource information, at health fairs and other community events.

Population-Based Services

CSHS clinic staff will work to increase awareness of State/Federal programs that serve CSHCN. CSHS Social Work Consultant will disseminate information, and train staff and community stakeholders on new programs and changes in policy for current programs. The CSHS website will be updated, as needed, with insurance resource information.

Infrastructure Building Services

CSHS will continue to partner with Medicaid to assure appropriate children are enrolled. CSHS staff will work with Medicaid and other carriers to ensure that applications and medical

information is submitted timely to facilitate eligibility decisions. CSHS will continue to work with Medicaid to ensure YSHCN maintain health coverage when they reach 19 years.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	70	70	70	70	75
Annual Indicator	68.8	68.8	68.8	89.3	89.3
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	90

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
CSHCN Survey data for 2005/2006 indicated that 89.3% of families of CSHCN in Louisiana reported that the community-based service system was organized so they could use it easily. This was an increase from the 68.8% reported in the 2001 CSHCN survey and exceeds the current national average of 89.1%.

Direct and Enabling
CSHS provided direct support systems for families in the CSHS clinic setting, with emphasis on linking families to community-based resources. CSHS staff and Parent Liaisons (PLs) worked in each CSHS clinic to assist families in locating and utilizing needed community-based services. CSHS placed a greater emphasis on Care Coordination and made an initial pilot of a developing Care Coordination Program in Region 1 (New Orleans). CSHS also stressed Transition from adolescent to adult care systems, and Medical Home, with CSHS staff and PLs reinforcing that these concepts be relayed to families and patients enrolled in CSHS. CSHS engaged in a concerted effort to have CSHS Social Workers work directly with Cystic Fibrosis patients utilizing private provider services to have all patients obtain health care coverage. Through contracting, CSHS continued to rebuild a physician provider network of pediatric subspecialists that had been disrupted since Hurricanes Katrina and Rita.

Population Based Services
PLs in CSHS worked with the Families Helping Families (FHF) staff to develop educational programs for families. Many programs had a focus on community resources and how to navigate systems to access services. FHF in all 9 regions presented these programs to families in their respective regions. CSHS also published a quarterly newsletter that was sent to all families receiving services in CSHS, as well as for families receiving services through FHF. The newsletter informed parents of current events, educational programs, new services and other information that was of interest for families of CSHCN. CSHS and FHF worked to better integrate PLs, FHF Health Information Specialists, and Department of Education funded Transition Specialists so that the knowledge and resources of these individuals might be leveraged by one another and any CYSHCN seeking services or referrals.

Infrastructure
CSHS continued development of a care coordination program for CYSHCN and families identified with intensive needs. CSHS worked with the Developmental Disability Council, the Louisiana Bright Start Initiative, Louisiana Medicaid, National Family Voices, FHF, and other organizations to ensure awareness of resources and facilitate appropriate referral for CYSHCN and their families

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide funding for CSHS staff and Parent Liaisons in all CSHS offices.	X	X		
2. Update regional resource manuals.	X	X	X	
3. Provide workshops and educational programs through PLs to families with CYSHCN	X	X	X	
4. Collaborate with community agencies and providers to facilitate access of services.			X	X
5. Continue piloting and expansion of Care Coordination .		X	X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Direct and Enabling Services
CSHS has staff and PLs in all regions of the state, providing direct consultation to families receiving services in the CSHS clinics to facilitate linkages to community-based resources. CSHS provides direct physician and medical services in all regions when such access otherwise does not exist. CSHS provides social workers in all regions of the state who are available for individual counseling or help to patients enrolled.

Population Based Services
The CSHS Parent Consultant and Parent Trainer provide quarterly trainings to all PLs to include strategies for working with families to keep them informed about community-based resources for CSHCN. The Louisiana Birth Defects Monitoring Network and the Newborn Hearing Screening Program provide referrals for community-based services, as need indicates. Both Programs have personnel available in Central Office who respond to public services and resource inquiries.

Infrastructure Building Services

CSHS administrative staff provide technical assistance to regional staff who began a pilot care coordination program in May. The care coordination software and regimen continue to be updated based on feedback from a working group of CSHS field staff. CSHS continues to collaborate with other agencies and providers in the state as services evolve in post-disaster settings. The CSHS website is updated with new links regularly. CSHS developed both a physicians guide and patients' brochure for marketing and education.

c. Plan for the Coming Year

Objective: 90% of families of children with special health care needs age 0 to 18 will report that community-based service systems are organized so they can use them easily. This new objective is based on the progress the 2005/2006 CSHCN survey data reflects.

Direct and Enabling Services

CSHS will serve families in clinics in each region of the state. CSHS will continue funding to provide CSHS staff to work with families on accessing community-based services. The PLs will update the regional resource manuals for staff use. The PLs and CSHS social worker personnel will work with Health Information and Transition Specialists to provide comprehensive resources for CYSHCN. The CSHS Parent Consultants will provide quarterly trainings to all PLs to assist them in working with families on access to community-based services.

Population Based Services

CSHS will provide educational programs for families which include activities aimed at accessing community-based services. CSHS will publish a quarterly newsletter for families of CYSHCN.

Infrastructure Building Services

Care coordination will be expanded to all nine regions of the state by the end of 2010. A birth defects registry currently exists in 4 regions of the state. Funding is being sought to expand this registry statewide and to provide parents with educational and resource information. CSHS will work closely with agencies in the state to share information and organize systems of referral for families. CSHS will continue to employ Statewide Parent Consultants to facilitate training programs for families and PLs statewide. The CSHS website will be updated to provide additional resources for families and interested persons to find regional, state and national information, and contact phone information related to CSHCN.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective		10	6	6	10
Annual Indicator	5.8	5.8	5.8	5.8	41
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**

Annual Performance Objective	44	44	44	44	44

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005
The data reported in 2005 are pre-populated with the data from 2004 for this performance measure.

a. Last Year's Accomplishments
The 2005/2006 CSHCN Survey shows 40.9% of YSHCN in Louisiana received services necessary to make transition to all aspects of life. The 2001 Survey result was 4.5%. However, the 2005/2006 age range for Outcome 6 was expanded from 13-17 to 12-17 years and several new questions were added. The annual performance objective was 10%

Direct and Enabling Services
CSHS staff completed the transition surveys in clinical settings and provided service coordination for YSHCN in transition. Staff provided follow-up and made referrals for all services as identified in the surveys and recommendations from CSHS staff physicians. One region continued the pilot Care Coordination (CC) program for CSHCN with intensive needs.

Population Based Services
CSHS worked statewide and regionally with other agencies, such as Louisiana Rehab Services and Office of Citizens with Developmental Disabilities, to facilitate services for YSHCN during transition. The CSHS website was updated after Hurricane Katrina to reflect changes in agency information and services.

Infrastructure Building Services
CSHS administrative staff worked closely with the pilot CC project. Staff from the pilot regions suggested major revisions to the program. Administrative staff began the process of incorporating these revisions into the CC process and accompanying database. Staff postponed a plan to begin training all staff in September 2007 until revisions were made and another pilot, based on revisions, could be done. In addition, CSHS worked to develop a Teen Transition Clinic in 2 regions of the state.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Screen all adolescents and young adults according to transition policy.	X	X		
2. Train staff on transition issues and services.			X	
3. Create partnerships to provide transition information to adolescent clients and their families.		X	X	X
4. Assist with the acquisition of services necessary to promote	X	X		

self-reliance and self-determination.				
5. Collaborate with multi-agencies to work on issues related to transition.				X
6. Develop Transition Clinics in 2 regions.				X
7. Complete the pilot care coordination in one region.	X	X		X
8. Train all CSHS staff on the systematic care coordination program.	X	X	X	X
9. Implement care coordination across all regions.	X	X		X
10.				

b. Current Activities

Direct and Enabling Services

CSHS did not initiate a Teen Transition Clinic in 2 regions in fall 2007. The physician who was to lead these clinics relocated out of state. CSHS is currently trying to identify another physician for the Transition Clinics. Economic instability/infrastructure deficits continue to impact recruitment/retention of pediatric subspecialists. Staff continued to use the transition survey in the clinical setting to identify areas of need during transition.

Population Based Services

CSHS updated its website to include a transition section with resource information. CSHS worked closely with other agencies to coordinate transition services. CSHS Parent Consultants conducted quarterly trainings for Parent Liaison (PL) staff, including transition issues and suggested revisions to CC.

Infrastructure Building Services

Staff made major revisions to the CC process and database. A pilot of the revised process will begin June 2008. Staff developed a strong evaluation component for the pilot. CSHS did not participate in the multi-disciplinary Transition Task Force because it did not re-form. Instead, CSHS staff initiated collaborative efforts with Louisiana Rehabilitation Services, Office for Citizens with Developmental Disabilities, Louisiana Department of Education, Families Helping Families, Family to Family Health Information Centers, and others to coordinate services for YSHCN and families in transition to adult services.

c. Plan for the Coming Year

Objective: 44% of YSHCN report receiving services necessary to make transitions to all aspects of life, including adult health care, work, and independence.

Direct and Enabling Services

Staff will pilot the revised CC process in one region from June through September 2008. Following program monitoring/process evaluation, staff will make necessary revisions based on results. Once CC is fully implemented in one region, staff will conduct an outcome evaluation. Staff will present findings of the CC evaluation at the annual statewide CSHS conference in October 2008. Staff will then implement CC across the state on a region-by-region basis.

Population Based services

The CSHS Parent Consultants will continue to conduct quarterly trainings for PLs, which will emphasize issues related to transition and the CC process. PLs play an essential role in the process and they will be trained as integral parts of the CC team. Once CC is successfully implemented in CSHS, staff will explore expansion of the program to non-CSHS YSHCN and families.

Infrastructure Building Services

CSHS will continue to pursue the feasibility of Teen Transition Clinics, based on physician availability and the success of the CC program. CSHS will participate in multi-agency

collaborations targeted at comprehensive, coordinated transition services for YSHCN.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	70	72	74	80	84
Annual Indicator	69.9	74.9	74.9	77	73
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	82	85	90	90	91

Notes - 2007
The National Immunization Survey (NIS) is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The survey is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. Estimates of vaccine coverage are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. Provisional 2007 data from the NIS survey for Louisiana indicates 72.5 + 7.0% of children within the ages of 19-35 months are at the appropriate immunization level for age for the vaccine series 4:3:1:3:3:1 which now includes 1 dose of Varicella vaccine in the series.

Notes - 2006
The National Immunization Survey (NIS) is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The survey is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. Estimates of vaccine coverage are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. Final 2006 data from the NIS survey for Louisiana indicates 77% of children within the ages of 19 – 35 months are at the appropriate immunization level for age for the vaccine series 4:3:1:3:3:1 which now includes 1 dose of Varicella vaccine in the series.

Notes - 2005
The National Immunization Survey (NIS) is sponsored by the National Immunization Program (NIP) and conducted jointly by NIP and the National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention. The survey is a list-assisted random-digit-dialing telephone survey followed by a mailed survey to children's immunization providers. Estimates of vaccine coverage are produced for the nation and for each of 78 Immunization Action Plan (IAP) areas, consisting of the 50 states, the District of Columbia, and 27 large urban areas. Final 2004 data from the NIS survey for Louisiana indicates 74.9% of children within the ages of 19 – 35 months

are at the appropriate immunization level for age.

For 2005, the immunization levels of children 19 – 35 months of age in Louisiana with 4 Diphtheria, tetanus, acellular Pertussis (DTaP), 3 Polio, 1 Measles-Mumps-Rubella (MMR), 3 Haemophilus Influenza Type B (HIB) and 3 Hepatitis B (HBV) – [4:3:1:3:3 schedule]] have not been determined by the National Immunization Survey (NIS). The annual estimate for Louisiana may not be complete as a result of the impact on Southeast Louisiana from Hurricane Katrina. The Center for Disease Control recognizes that the validation of the survey and the multiple parishes impacted as well as the loss of immunization records by parents and medical providers will likely impede the survey results since the survey design is by random telephone dialing methodology.

a. Last Year's Accomplishments

Direct Services

The CDC National Immunization Survey has indicated Louisiana's immunization coverage rate declined in 2006 at 69.7% compared to 2005 at 74.1%, dropping Louisiana's national ranking from 32nd to 44th place. The Immunization Program continues to strive to meet the primary goal toward achieving the 2010 Health Objectives of 90% immunization coverage rates among children through age two. The Program provides vaccines to all VFC-eligible children with an estimate of over 1 million doses distributed to both private and public health care providers statewide. It is increasingly evident that immunization services offered in the public health sector has decreased significantly such that the focus to meet the national objective is to strengthen our partnership with private providers.

Infrastructure Building Services

The number of Vaccines for Children (VFC)/Assessment, Feedback, Incentives, & Exchange (AFIX) onsite visits has increased as a result of hiring additional staffing to conduct quality assessment visits and to provide feedback to VFC providers. The VFC program priorities continue to enhance the Immunization Program's ability to assess and improve immunization delivery practices at the provider's level to assure that VFC eligible children are receiving quality services. The Immunization Program adopted the Shots for Tots by One campaign as a measure to optimize childhood immunizations for protection against 12 different childhood diseases by the completion of approximately 20 doses of various vaccines required by 12 months of age.

Louisiana Immunization Network for Kids Statewide (LINKS) registry continues to expand in the enrollment numbers of VFC providers and has collaborated with the Medicaid Program's incentive pay-for-performance initiative as a means in increasing the utilization and participation with the LINKS registry by VFC providers. The School Nurse LINKS module has been implemented statewide where almost all public schools are enrolled in the LINKS registry for all first-time school enterers with the exception of 2 schools in Region 4. Approximately 80% of private schools and 60% of Headstart centers are also reporting through the LINKS registry.

Monthly reminder/recall immunization drills were conducted for age groups 0 -- 6 years of age and 11-13 years of age where postcard reminder notices were mailed utilizing the LINKS system data in collaboration with the US Postal Service to inform parents of the need to update their children's immunizations. One of the reminder/recall drills was conducted in collaboration with Wyeth Pharmaceuticals whereby postcard reminder notices were written in both English and Spanish. Approximately 25% of private providers utilize the LINKS reminder/recall feature to issue immunization update reminder notices to their clientele. The LINKS system has the capacity to recall children for whom vaccine deferment due to vaccine shortage (i.e.,Hib vaccine) to return to their health care provider for vaccine update.

The 15th annual Shots for Tots (SFT) Conference was held in November 2007 in New Orleans. The SFT Conference received continuing education credits for attendees who completed the required documentation. The goal of the conference was to continue providing ongoing information to all health care providers in the delivery of comprehensive immunization services for

all age groups, to explore innovative strategies for improving immunization coverage rates through policy and program development and to provide the latest scientific information on newly developed vaccines.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Supply vaccines to enrolled providers through the Vaccines for Children (VFC) program.			X	
2. Expand VFC provider enrollment.			X	X
3. Expand on-site VFC/AFIX (Assessment Feedback Information Exchange) active provider sites.				X
4. Expand the Louisiana Immunization Network for Kids Statewide (LINKS) by integrating data systems and partnering with other providers to enhance vaccination coverage.				X
5. Enhance efforts to provide immunizations in public health units monitored by CASA state surveillance reviews.	X		X	X
6. Coordinate with Medicaid Program with pay-for-performance incentives to improve immunization practices.	X			X
7. Annual Shots for Tots Conference.				X
8. Conduct immunization reminder/recall notifications monthly.		X		
9.				
10.				

b. Current Activities

Direct Services

In April 2008, National Infant Immunization Week was held to promote the benefits of immunizations and to focus on the importance of immunizing infants by age one. This year the Louisiana Shots for Tots Coalition purchased 175 banners that read "Love them, Protect them, Vaccinate them!" to be placed across the state at both public and private immunization facilities. The coalition of public/private entities worked cooperatively to educate parents/providers in order to ensure the highest level of immunizations possible. In this effort, all parish health units waived the normal $10 administrative fee and accepted all walk-in clients. These activities are part of the state's strategy for having every child up to date by age one. In October 2007, a statewide mass influenza vaccination exercise was conducted for the general public to obtain influenza vaccinations for the entire spectrum of age groups. Over 27,000 vaccinations were given in a 6-hour period.

Infrastructure Building Services

Enhancement of the LINKS registry continues by populating the registry with data-merges of batched immunization data from institutional-based systems such as Medicaid, Ochsner health system sites and other hospital-based management systems. The registry allows for comprehensive vaccine record-keeping system of all children who receive immunizations statewide. The Mass Immunization Module portion of LINKS was utilized for outbreak control and management for two separate outbreaks.

c. Plan for the Coming Year

Objective: To improve the current statewide vaccination coverage rate by 3 -- 5% among children 19 -- 35 months of age for year 2008-2009 with completion of the 4:3::3:1:3 series for Louisiana to achieve the 2010 National Performance Objective.

The projected plan will be to continue VFC-AFIX community-based trainings that will incorporate

best practices from all components of the immunization program including customer service, vaccine management and assessment, appropriate delivery of immunizations and use of the registry.

Ongoing collaboration with the Medicaid pay-for-performance initiative will continue to expand provider enrollment and improve immunization service delivery at primary care sites with the integration of the statewide registry into the provider's practice. Feedback from provider usage exchange data with Medicaid is anticipated to demonstrate the success of the pay-for-performance initiative. Enrollment of all school nurses, private schools and Headstart centers statewide in the utilization of the LINKS system will continue. These users have been proven to be avid registry users that possess credible immunization history data that is otherwise unobtainable from private providers. Other potential institutional data base system exchange integration with LINKS is being planned with other large HMOs, billing vendors and hospitals. Reminder/recall notifications on a monthly basis to inform parents of the need to update their children's records will continue throughout the year utilizing the LINKS database in collaboration with the US Postal Service.

Plans for the 16th annual Shots for Tots Coalition conference are underway for November 2008 to be held in New Orleans. Arrangements for conference agenda guest speakers and offering of continuing education credits are in progress. This immunization coalition sponsored conference continues to provide a solid partnership to engage all community sectors in immunization improvement strategies.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	32	31	30	29	25
Annual Indicator	29.3	29.2	26.6	29.5	29.5
Numerator	2984	2955	2670	2776	2776
Denominator	101974	101048	100211	94142	94142
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	25	24.5	24	24	24

Notes - 2007
Data for 2007 is provisional and based upon 2006 data.

Notes - 2006
The 2006 data is provisional.

Notes - 2005
Data for 2005 is final.

a. Last Year's Accomplishments

Direct Services

The rate of birth for teenagers aged 15 through 17 years has declined since 2003 and 2004. The actual indicator has consistently been better than the annual performance objective each year. In 2005, the rate of birth (per 1,000) for teenagers aged 15 through 17 years was 26.6. From 2004 to 2005, there was a nine percent decrease in the rate, which was 11% below the annual performance objective. The Family Planning Program (FPP) provided comprehensive reproductive health care services to adolescents in 69 state-administered facilities and 8 contract sites. In 2007, 4,736 teenagers aged 15 through 17 utilized family planning services, of which 4,585 users were females.

Enabling Services

Prioritizing adolescent scheduling in Family Planning clinics reinforced the efforts to reduce teen pregnancy. Teen pregnancy prevention efforts included high priority scheduling, outreach activities and family involvement trainings. Collaborative teen pregnancy prevention efforts were continued and strengthened with community-based organizations working with adolescents.

Infrastructure Building Services

The Mystery Caller Quality Assurance Study was conducted again to identify waiting time for a Family Planning clinic visit. The Mystery Caller Study has proven itself to be an effective means to accurately identify the level of need for family planning services. The results verified that adolescents are given priority in scheduling.

The FPP in conjunction with The Center for Health Training conducted statewide training programs and provided technical assistance on attracting adolescents to clinics. In an effort to increase parental involvement in adolescent reproductive heath care and other adolescent topics, Women's Health 5th Friday videoconferences on "Family Involvement and Clinic Efficiency" were held for Family Planning clinical and clerical staff reaching over 350 staff members statewide.

Population Based

The FPP distributed information and educational materials to inform, teach and encourage teens in the prevention of teen pregnancy. Educational materials designed especially for teens addressed avoiding sexual coercion, deciding about sex, HIV/AIDS and STD. Effective education and outreach has contributed to a decline in teen pregnancy and births due to effective use of contraceptives.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide comprehensive reproductive health care services to adolescents.	X			
2. Present and distribute education materials to teens and professionals.		X	X	
3. Provide technical assistance on teen pregnancy prevention mass media campaigns.			X	X
4. Provide training manual to clinic nurses for education on adolescent reproductive health issues.				X
5. Conduct Mystery Caller Study to assess adolescent need.				X
6. Promote clinical trainings to create a teen-friendly environment and increase teen utilization.				X
7.				
8.				

9.				
10.				

b. Current Activities

Direct and Enabling Services

The FPP provides reproductive health care services to teens statewide and prioritizes adolescent scheduling in family planning clinics. To specifically target the adolescent community, the statewide Health Education & Outreach Coordinator conducted a needs assessment survey and facilitated focus groups in Family Planning clinics. Outreach activities are conducted by Family Planning contract sites and services are provided solely to adolescents. Educational materials are issued to adolescents to inform, teach and encourage pregnancy prevention.

Infrastructure Building Services

The Health Education and Outreach Coordinator is currently developing a statewide Health Education and Outreach Plan to better serve adolescents in the community and attract adolescents to clinics. The FPP promotes folic acid for all women of childbearing age to help prevent neural tube defects.

Working with the Center for Health Training, the FPP continues to provide training sessions for Women's Health 5th Friday. Adolescent reproductive heath care and other adolescent topics, "Confidentiality and Customer Service for Minors, New and Emerging Contraceptive Methods, and Clinic Efficiency and Patient Scheduling" were held. The Mystery Caller Quality Assurance Study is being conducted to ensure that adolescents are given priority in the family planning clinic schedule.

c. Plan for the Coming Year

Objective: Decrease birth rate to 29 (per 1000) for teenagers aged 15 through 17 years.

Direct and Enabling Services

The FPP will continue to provide reproductive health care services to teens statewide. Adolescent scheduling in Family Planning clinics will continue as a priority. The Statewide Health Education & Outreach Coordinator will continue to develop and strengthen community-based organizations working with adolescents.

Infrastructure Building Services

The statewide Health Education and Outreach Plan will target adolescents and focus on enhancing local capacity to provide outreach that will facilitate and increase clinic attendance, as well as providing appropriate information and educational materials.

Starting July 1, 2008, the FPP will offer folic acid to all female clients capable of becoming pregnant in an effort to reduce birth defect rates in Louisiana. The FPP will continue to work toward increasing parental involvement in adolescent reproductive heath care, thus provide trainings on pre-conception care counseling, family involvement, new and emerging methods of contraception and preventing partner violence. The FPP will continue to use The Mystery Caller Quality Assurance Study to assess the needs of adolescents and service availability.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007

Annual Performance Objective	20	20	20	20	20
Annual Indicator	18.0	18.0	18.0	18.0	18.0
Numerator	157	157	157	157	157
Denominator	871	871	871	871	871
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	23	23	23	25	25

Notes - 2007
The State Oral Health Program has begun collecting sealant prevalence data on 3rd graders statewide, every 5 years. This data is used to tabulate the sealant prevalence rate for FY2006 because the Oral Health Program is confident that this data more accurately reflects the sealant status of this population than the data previously collected more than 5 years ago.

Notes - 2006
The State Oral Health Program has begun collecting sealant prevalence data on 3rd graders statewide, every 5 years. This data is used to tabulate the sealant prevalence rate for FY2006 because the Oral Health Program is confident that this data more accurately reflects the sealant status of this population than the data previously collected more than 5 years ago.

Notes - 2005
The State Oral Health Program has begun collecting sealant prevalence data on 3rd graders statewide, every 5 years. This data is used to tabulate the sealant prevalence rate for FY2005 because the Oral Health Program is confident that this data more accurately reflects the sealant status of this population than the data previously collected more than 5 years ago.

a. Last Year's Accomplishments
Direct Services
The MCH Oral Health Program continued to expand the dental sealant program for 1st and 2nd graders in an effort to increase the number of children with dental sealants. Nine parishes participated in the program last year, including 3 new parishes, Evangeline, Lafayette, and West Feliciana. In Washington Parish the children were screened and the program provided dental screenings and dental sealants on the 1st molar teeth of eligible children. The sealant program continued in Concordia, Catahoula, Allen, Avoyelles, and East Feliciana Parishes. In the 42 schools that participated, a total of 2207 students received oral health screening, 28% of 1st and 2nd graders in participating schools received dental sealants, and 5644 dental sealants were placed.

Enabling Services
MCH Oral Health Program staff continued to partner with Medicaid outreach efforts to ensure that eligible pregnant women received needed dental services. The Oral Health Program staff and the Medicaid program administrative staff attended the New Orleans Dental Conference and Louisiana Dental Association Annual Meeting to promote provider enrollment in the dental Medicaid program. Program material was disseminated and the oral health program staff offered information to update providers on Medicaid policy changes and administrative issues regarding the dental services program for pregnant women.

Infrastructure Services
The Oral Health Program added two new staff in June 2007. The Oral Health Program Manager is responsible for the programmatic functions of the program, focusing on fluoridation. The new

Program Monitor is a trained epidemiologist currently focusing on the oral health assessment project. In addition, the Oral Health Program Director participated in the training of the first cohort of the National Oral Health Leadership Institute in August 2007.

Population Based Services
The Fluoridation Program continued to address efforts to fluoridate the cities of Baton Rouge, Crowley, and Walker. The program, in partnership with the Louisiana Dental Association, the LSU School of Dentistry, members of the Fluoridation Advisory Board, and staff of the Oral Health program, presented a study resolution to the Louisiana Legislature, House Committee on Health and Welfare and the Senate Committee on Health and Welfare. The report presented the scientific, health, technical, economic, and related issues of the feasibility of mandated community water fluoridation. In October 2007, the Fluoridation Engineer conducted a needs assessment of all public water systems to determine needs for technical assistance.

At the September 14, 2007 meeting of the Fluoride Advisory Board, the board moved to request a reallocation of the Preventive Health and Health Services block grant funding to expand fluoridation efforts. This additional funding will be dedicated to education and to assisting communities to replace aging or broken equipment, allowing communities to continue fluoridation.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Expansion of the dental sealant program into three new parishes.	X		X	
2. Development sustainability plan for a dental sealant program model for statewide application in Louisiana.	X			X
3. Partnered with LDA to provide dental sealants on Give Kids a Smile Day.			X	X
4. Sealant program participants receive oral hygiene instruction and oral health aids to promote improvement of oral health.	X	X		
5. Determining retention rates of sealants in program in a sample of participants.	X		X	
6. Identifying funding sources for the expansion of the sealant program.			X	X
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services
The Oral Health Program (OHP) is administering the school-based dental sealant program in cooperation with public and private partnerships. These service partners include community health centers and dental providers in private practice.

Enabling Services
MCH continues to partner with Medicaid outreach efforts to ensure that eligible pregnant women received needed dental services. The OHP conducted a telephone survey of the dentist in areas most impacted by the 2005 hurricanes, to determine barriers to service and identify problems.

Infrastructure Services
School nurses representing all geographical regions of the state are being trained to provide the oral health screening on 3rd grade children. A representative sample of 3rd grade children is

being screened statewide. In March 2008, an Oral Health Forum was held with dental sealant program partners as well as other key stakeholder to discuss dental sealant program expansion plans.

Population Based Services
Forty percent of Louisiana's population is receiving fluoridated water. In May 2008, the city of Crowley began to adjust the water to deliver optimally fluoridated water to the nearly 20,000 citizens served by the water company. The Fluoridation Program is assisting the town of Walker as they begin the design and construction phase to initiate fluoridation.

c. Plan for the Coming Year
Direct Services
The Oral Health Program will work toward increasing the number of children who receive protective dental sealants through school-based sealant programs. A sustainability plan will continue to be developed identifying policy changes needed and Medicaid reimbursement opportunities.

Enabling Services
In order to promote the Pregnant Women's program, MCH will work toward increasing the number of dental providers treating Medicaid children and Medicaid eligible pregnant women. MCH will provide continuing education and program information to dental health providers in the state in forums such as dental society meetings and annual state conferences.

Infrastructure Services
The Oral Health Program (OHP) has applied for a CDC state program cooperative agreement. If funding is granted, the program will add two additional staff, staff to manage the school-based/linked sealant program, a Fluoridation Specialist to work with the water systems, and staff to develop an Oral Health Coalition.

Population Based Services
The Fluoridation program will implement an ongoing training program for water operators to ensure safe and consistent delivery of the optimal levels of the fluoride ion and promote the benefits of community water fluoridation. The program, in partnership with the OPH Engineering Services Section, will present training on the benefits and myths of water fluoridation to the Regional and District Engineers. The program will continue efforts to initiate fluoridation in St. Bernard and East Baton Rouge parishes. The program is producing a brochure and display educating on the benefits of water fluoridation. The program is reviewing reporting procedures, Louisiana's compliance with the CDC Engineer and Administrative Recommendations for Water Fluoridation and updating the Fluoridation Procedures Manual for local operators.

The OHP will work to increase the number of Louisiana residents who receive the protective benefit of community water fluoridation. It is anticipated that the Town of Walker will initiate fluoridation in October of 2008. Plans also include providing additional financial and technical support to systems to continue fluoridation.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	6.9	6.7	6.7	6.7	4

Annual Indicator	4.6	7.0	5.2	4.2	4.2
Numerator	45	67	49	38	38
Denominator	973127	963046	946320	897508	897508
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	4	4	4	4	4

Notes - 2007
2007 data is provisional and based upon the 2006 data.

Notes - 2006
2006 data is provisional.

a. Last Year's Accomplishments
In 2006, 38 children aged 0-14 years were killed in motor vehicle crashes for a preliminary rate of 4.2 deaths/100,000 children. This preliminary rate is lower than the Healthy People 2010's goal of 9.0 deaths by motor vehicle crashes/100,000 population. This rate is also lower than the final rates for 2003, 2004, and 2005, which are 4.6, 7.0, and 5.1 deaths/100,000 children, respectively. Data for 2007 is not yet available for reporting.

The Maternal and Child Health (MCH) Program and the Injury Research and Prevention (IRP) Program worked towards reducing child vehicular deaths. MCH funded the Louisiana's 9 Regional Maternal and Child Health Injury Prevention (MCH IP) Coordinators (now called MCH Child Safety Coordinators) and the Safe Kids Louisiana Program.

Population-Based Services:
The MCH Program continued to support the Regional MCH IP (Child Safety) Coordinators' participation in car seat/child restraint check-up events, in collaboration with Safe Kids Louisiana, the Louisiana Passenger Safety Task Force, and Louisiana Highway Safety Commission. In 2006, the MCH IP Coordinators participated in child restraint check-up events statewide, which reached more than 4,000 people, and more than 1,689 seats/child restraints were checked at check-up events and fitting stations. In 2007, more than 3,100 people participated statewide in more than 84 local child passenger safety events, and 1,544 seats/child restraints were checked at check-up events and at fitting stations.

The MCH IP (Child Safety) coordinators and Safe Kids coordinators continued to offer child restraint technical assistance and educational outreach to healthcare providers, educators, childcare centers, and community leaders through seminars and workshops. Community outreach was continued via health fairs; the media (radio and television); printed materials (brochures, newsletters, pamphlets); and presentations to such groups as schools and faith-based organizations. Culturally appropriate outreach activities conducted statewide by the MCHIP coordinators reached more than 30,000 children and adults in 2006 and more than 38,365 in 2007.

Infrastructure Building Services
The State and the local Child Death Review Panels (CDRP) continued to review all unexpected deaths of children under the age of 15 years resulting from motor vehicle crashes and other causes. The regional/local MCHIP coordinators continued to serve as the regional/local CDRP

coordinators.In 2007, at least 89 unexpected child deaths were reviewed in 18 CDRP meetings, and at least 58 child deaths were reviewed in 18 CDRP meetings in 2006. There were also 99 sudden unexplained infant deaths reviewed at the state level of Child Death Review in 2007.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. LA SAFE KIDS and MCHIP coordinators will conduct/assist with monthly car seat check-up events, in collaboration with the Louisiana Passenger Safety Task Force and Louisiana Highway Safety Commission.			X	
2. MCHIP coordinators to distribute car seats and booster seats, if available, to needy children.			X	
3. MCH to provide technical assistance and collaborate with the OPH EMS/ Injury Research & Prevention Section on childhood injury and motor vehicle occupant injury prevention activities.				X
4. Support the outreach efforts of Louisiana SAFE KIDS and the nine regional MCHIP coordinators to provide safety/injury prevention education and resources.				X
5. Louisiana SAFE KIDS and MCHIP coordinators will collaborate with epidemiology colleagues to report injury data to implement effective child motor vehicle occupant and other injury prevention interventions.				X
6. Child Death Review Panels will review all unexpected deaths of children under the age of 15 years resulting from motor vehicle crashes and other causes.				X
7.				
8.				
9.				
10.				

b. Current Activities
Population Based Services:

The MCH Child Safety (IP) Coordinators, as certified Child Passenger Safety Technicians, have continued car/booster seat distribution and car seat/child restraint check-up events/fitting station participation in collaboration with Safe Kids Louisiana, Louisiana Passenger Safety Task Force, and Louisiana Highway Safety Commission. Since January 2008, 405 car seats/restraints were checked.

Infrastructure Building Services
MCH Child Safety (IP) Coordinators, in collaboration with Safe Kids Louisiana, offer technical assistance and culturally appropriate, community-based injury prevention educational outreach through health fairs, seminars, workshops, media, and English/Spanish printed materials. Since January 2008, over 12,576 people were reached in over 116 events statewide.

The State/Local Child Death Review Panels continue to review unexpected deaths of children 14 years and under resulting from motor vehicle crashes and other causes. Child Safety Coordinators are also the local CDRP coordinators and collaborate with community leaders, Safe Kids Louisiana, EMS for Children, and Injury Research and Prevention Program to implement effective injury prevention interventions. Since January 2008, 33 child death cases were reviewed.

MCH, Louisiana CDRP, and the National Center for Child Death Review held a training on effective infant/child death investigations and reviews for the CDRP coordinators and professionals statewide who investigate child deaths.

c. Plan for the Coming Year
Objective: To decrease to 6.3 per 100,000 children the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

Population-Based Services
The MCH Child Safety Coordinators will continue to distribute car seats and booster seats, if available, to children in need and will continue to participate in car seat/child restraint check-up events and fitting stations, in collaboration with Safe Kids Louisiana, Louisiana Passenger Safety Task Force, and Louisiana Highway Safety Commission.

Infrastructure Building Services
In order to reach our objective, the MCH program will continue to support the MCH Child Safety Coordinators and Safe Kids Louisiana to provide technical assistance, injury prevention educational outreach, and motor vehicle occupant injury prevention activities, which are community-based and culturally appropriate for the target at-risk populations. The educational materials are also available in Spanish for the growing Hispanic population with limited proficiency of the English language in Louisiana.

The State and Local/Regional Child Death Review Panels will continue to review all unexpected deaths of children under the age of 15 years resulting from motor vehicle crashes and other causes. MCH and the Louisiana Child Death Review will implement the CDC web-based case reporting system of infant and child death review findings for both the State and Local CDRPs. The MCH Program will continue to support childhood injury prevention interventions, developed from which result from State and Local CDRPs, in collaboration with the Safe Kids, OPH EMS for Children and Injury Research & Prevention Program.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				10.4	15.6
Annual Indicator		15.2	15.2	15.2	15.2
Numerator		9253	9253	9253	9253
Denominator		60873	60873	60873	60873
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	15.8	16	16.2	16.2	16.2

Notes - 2007

Data is provisional and based upon 2004 PRAM data.

Notes - 2006
Data is provisional and based upon 2004 PRAMS Data.

Notes - 2005
Data is provisional and based on 2003 PRAMS data.

a. Last Year's Accomplishments
The Centers for Disease Control (CDC) report in "Breastfeeding Report Card -- United States, 2007" that the average for mothers breastfeeding at 6 months of age is 41.5 % in the U.S. and 19.2% in Louisiana. The 2004 Louisiana PRAMS final data shows an average for mother's breastfeeding at 6 months of age to be 15.2%.

Enabling Services
WIC was able to provide each of its sites with additional breast pumps to support both the hurricane affected New Orleans and Lake Charles area clinics which lost a substantial portion of these items. WIC also supplemented those areas in need of additional supplies as a result of increased need due to relocation of participants. The breastfeeding Peer Counseling program began operation by hiring and formally training staff using two national trainers and a national training curriculum. This program began their client support around the state. Culturally appropriate breastfeeding educational materials and language line translators were used to facilitate client support.

Population Based Services
Local breastfeeding coalitions were established in the New Orleans and Central Louisiana areas. Breastfeeding support and outreach were conducted with faith based organizations, community level groups, local universities, physician's offices and other health care providers. Culturally appropriate breastfeeding educational materials were provided for use in facilitating client support. Breastfeeding educational materials and physicians support kits were provided by The Gift (Guided Infant Feeding Techniques) program to promote breastfeeding and assure breastfeeding-friendly policies regarding lactation support and how infant formula is handled at the birthing hospitals and birthing centers, has been implemented since September 2006. From October 1, 2006 to September 30, 2007 The Gift enrolled a total of five birthing facilities and one free-standing birthing center in the program and received designation as "Gift Certified." In addition to working with each birthing facility to meet the guidelines for "Gift Certification", administrators and staff of 50 birthing hospitals throughout the state were contacted to encourage their participation in the program. Program materials were also sent to these individuals. Presentations were given at facilities seeking more information about The Gift. Program outreach/education materials were developed and updated on a regular basis. An assessment tool was created in order to better assist facilities in establishing gaps in breastfeeding support at their facility. A hosted- listserv and statewide email list was created to disseminate information about The Gift, newly certified facilities, and other breastfeeding information. The Gift Program Coordinator actively participated in local and statewide breastfeeding groups and coalitions. A needs assessment for a breastfeeding training program was developed and conducted. A write-up about The Gift was published in the Louisiana Chapter of the AAP Newsletter and the AAP Section on Breastfeeding Newsletter.

Infrastructure Building Services
Work continued on updating the statewide breastfeeding resource guide with information on WIC clinic breastfeeding coordinators, local La Leche League groups and leaders, hospital lactation consultants and breastfeeding services and individuals offering breastfeeding services. Staff was provided updated breastfeeding policy and procedures on the OPH Nutrition Service Website. Breastfeeding support and educational materials were piloted with prenatal participants in one region of the state and after evaluation of the project the materials will be offered to all prenatal participants statewide.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of hospital grade and portable electric breast pumps.		X		
2. Collection and analysis of WIC breastfeeding initiation and duration at 6 months of age rates.				X
3. Revision of breastfeeding policies and procedures including on-line breastfeeding training for all clinic staff and monitoring of positive clinic environment that endorses breastfeeding.				X
4. Establishment of State Breastfeeding Coalitions with inclusion of community organizations.			X	X
5. Provision of breastfeeding educational materials to promote breastfeeding at birthing hospitals through The Gift project.		X	X	X
6. Upgrade and utilization of culturally appropriate breastfeeding educational DVDs, handouts, and posters.		X	X	
7. Provision of breastfeeding classes for prenatal, postpartum and breastfeeding participants.				X
8. Provision of breastfeeding support and education materials for family members of breastfeeding clients.				X
9. Provision of breastfeeding peer counselors to support breastfeeding initiation and duration.		X		
10. Establishment of breastfeeding worksite promotion and support.			X	

b. Current Activities

Enabling Services

All WIC sites continue to endorse breastfeeding as the preferred method of infant feeding. Updated and culturally appropriate breastfeeding educational items are provided. OPH Nutrition Services website now includes links to more comprehensive breastfeeding educational information for staff use. Structured breastfeeding classes are offered and breastfeeding peer counselors are providing support to the participants. Manual, personal and hospital grade breast pumps are available to clinics.

Population Based Service

Formation of a statewide breastfeeding coalition is in progress with participation of local breastfeeding support groups, the Louisiana WIC Program, the Maternal Child Health Coalition and the American Academy of Pediatrics breastfeeding representatives.

Infrastructure Building Services

The statewide breastfeeding resource guide is updated and was distributed during the Nurse Family Partnership conference held April 2-4, 2008. Breastfeeding awareness at the community level includes participation with local military installations, faith-based organizations, daycare and Head Start programs, physicians' offices, other health care providers and community entities. The Gift initiative targeting birthing hospitals with outreach, health promotion, and public/professional education has enrolled two additional birthing hospitals since October 1, 2007. There are currently eight "Gift Certified" facilities, with one application currently in progress.

c. Plan for the Coming Year

Objective: Increase to 15.2 percentage the proportion of mothers who breastfeed their infants at 6 months of age.

Enabling Services
WIC will work to strengthen the breastfeeding peer-counseling program and it's affect on our breastfeeding initiation and duration rates in the areas of operation. The United States Department of Agriculture/ Food and Nutrition Services has provided the state with additional funds targeted for the breastfeeding peer counseling program. All WIC sites will continue to promote and create clinic environments that endorse breastfeeding as the preferred method of infant feeding. Clinics will continue to address large disparities seen among the different racial and ethnic groups by providing updated and culturally appropriate breastfeeding educational offerings. Breastfeeding classes will continue to be offered to prenatal, postpartum and breastfeeding participants. WIC will continue to provide manual breast pumps, hospital grade electric breast pumps and personal electric breast pumps to participants as needed.

Population Based Services
The Maternal Child Health Coalition, the Louisiana WIC Breastfeeding Program, the Greater New Orleans Breastfeeding Awareness Committee, the Central Louisiana Breastfeeding Coalition, the American Academy of Pediatric Breastfeeding Coordinator, LA Leche League and the Louisiana Lactation Consultant Association will all work in conjunction to form a state breastfeeding coalition for a combined effort at increasing the state breastfeeding initiation and duration rates. The different breastfeeding entities will work on recruiting local businesses statewide to become breastfeeding friendly employers and help the businesses to successfully establish breastfeeding rooms and policies at their worksites. A media program will be implemented to focus on the breastfeeding peer counseling program and breastfeeding in emergencies.

Infrastructure Building Services
The statewide breastfeeding resource guide will be updated on a continual basis to reflect changes in new staff, breastfeeding peer counselors, local and state breastfeeding coalitions, La Leche League groups, hospital lactation consultants and individuals offering breastfeeding assistance and support throughout the state. A link on the OPH Nutrition Services Website will offer comprehensive breastfeeding information. All prenatal WIC participants will receive breastfeeding promotional information in an effort to impact their decision to choose breastfeeding as the preferred method of feeding their infant.

Three main initiatives will be the focus of The Gift program in the upcoming year. These initiatives include: continue a hospital incentive program called The Gift (Guided Infant Feeding Techniques); provide breastfeeding training offered with Continuing Education (CE) credits; and organize and mobilize a statewide breastfeeding coalition.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	85	93	95	98	98
Annual Indicator	92.6	95.9	96.3	95.9	96.6
Numerator	59230	61984	41228	52801	61440
Denominator	63965	64636	42825	55084	63630
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3					

years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	98	98	98	99	99

Notes - 2007
Data is still provisional.

Notes - 2006
Data is based on entire year, but not all occurrent birhts are represented due to problems with the EBC server failure following Hurricanes Katrina and Rita.

Notes - 2005
Data is based upon January to July 2005 time period. After Hurricanes Katrina and Rita in August/September 2005, the Electronic Birth Certificate and Early Hearing Detection and Intervention (EHDI) database was not functional until March 2006.

a. Last Year's Accomplishments
During 2006, the program screened 95.41% of newborns for hearing loss. Data is not complete due to the failure of the electronic birth certificate (EBC), but represents about 89 percent of occurrent births. Preliminary data for 2007 reflects 96.5% screened. This represents an increase for the performance objective from last year. The percentage of infants screened is affected by HSV data collection not receiving information for infant transfers and deaths, unless hospitals report by paper form. The program sought to reduce the morbidity, developmental and educational delays associated with hearing loss. The goal of this program is to meet the American Association of Pediatrics' (AAP) 1-3-6 guidelines for screening, identification and intervention.

Direct Services
Newborn hearing screening services are mandated by law and provided by all 60 birthing hospitals. Follow-up testing for those who did not pass the screening was provided by both the public and private sector. Follow-up data is reported directly to HSV via the Follow-Up Services Report. Direct services were provided by HSV audiologists, providing services for children who lack insurance or access to services. They provided 454 hearing and speech screenings for infants and toddlers; 742 audiological evaluations to CSHS eligible children; 328 hearing aids to CSHS eligible children. These services reflect an increase similar to statistics prior to Hurricanes Katrina and Rita.

Enabling Services
HSV distributed informational brochures for parents about newborn hearing screening and follow-up for children referred, in both English and Spanish. HSV provided in-services and written information to Primary Care Physicians (PCPs), who have purchased screening equipment, to educate and inform them about Universal Newborn Hearing Screening and Intervention (UNHSI) and the importance of reporting follow-up data to UNHSI. The HSV statewide Parent Consultant participated with parents to establish a chapter of Hands and Voices, a parent-driven, non-biased organization for families with children with hearing loss. The HSV parent consultant also provided input on policy and system issues, as well as individual parent support.

Population-Based Services
UNHSI is a population-based program that legislatively mandates hearing screening for all babies born in Louisiana prior to hospital discharge. Screening was completed by all 60 birthing hospitals. Hospitals are required to report screening results to the UNHSI program. HSV completed comprehensive on-site hospital visits with half of all birthing hospitals. HSV provided technical assistance to improve accuracy of hearing screening and follow-up data via the EBC, and to assure compliance with all components of the UNHSI system: data reporting, records,

program policies, parent education, and identification of providers performing follow-up testing. HSV also instituted a system for hospitals to report infant transfers and deaths not provided with the hearing data from the EBC. When hospitals sent information by paper form, HSV adjusted hospital statistics for those children whom they could not screen, due to transfers to a NICU or due to death. HSV received the hearing data from the NICU receiving hospital by paper. The HSV Follow-Up Coordinator left the program after one year. A search was begun for a new contractor for the position. The lack of initial screening data from the EBC precluded the implementation of plans for reducing the number of infants lost to follow-up.

Infrastructure Building Services
With the restoration of the Vital Records (VR) server, HSV provided hospitals with quarterly reports of their screening and follow-up performance, which improved accuracy of data. HSV provided on-going educational training through the regional task force system as well as comprehensive hospital visits. HSV completed training with UNHSI guideline documents: Pediatric Audiology Guidelines; Audiological Rescreening of Infants Guidelines. EarlySteps (Part C) restored eligibility for children with unilateral hearing loss while under CSHS.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Improve hospital data accuracy; work with VR & IT in re-design of EBC and hearing data system.				X
2. Provide training and standards for early hearing detection and intervention personnel.				X
3. Provide parent education, outreach and support; disseminate pamphlets in English and Spanish.		X	X	
4. Follow-up and tracking systems for children suspected of hearing loss.				X
5. Provide audiology follow-up for UNHSI where there is no access to community services.	X	X		
6. Provide hearing aids for identified children who have no access to community services.	X	X		
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services
Audiological services are provided by the HSV audiologists where there is a lack of local services.

Enabling Services
Distribution of English and Spanish brochures for parents is on-going. The program continues to foster parent groups, e.g. Louisiana Hands and Voices. The parent resource guide has been completed. Guideline documents continue to be distributed. The HSV Parent Consultant has recently left the position. Interviews are scheduled for a new parent for this position.

Population-Based Services
HSV is collecting data on newborn hearing screening and implementing a follow-up system to ensure that all infants who referred receive appropriate follow-up. HSV contracted a Follow-Up Coordinator to improve the system.

Infrastructure Building Services

Monitoring activities, training, and technical support services for UNHSI are ongoing. HSV resumed quarterly reports to hospital UNHSI supervisors. Efforts to provide materials and training about UNHSI for PCPs are on-going to improve reporting of follow-up rescreening. The HSV program began work with in-house IT to re-design the hearing database to a centralized, secure, web based data system. HSV initiated a Memorandum of Understanding (MOU) for data sharing with Office of Citizens for Developmental Disabilities (OCDD), the lead agency for EarlySteps as of July, 2007.

c. Plan for the Coming Year

Objective: To increase the proportion of newborns that are screened for hearing loss before hospital discharge to 98%. The goal for number of infants screened has been reduced to 98%, until VR and our hearing data collection can be changed to electronically collect infant transfers and deaths.

Direct Services

Screening and follow-up services will continue to be provided by the HSV audiologists where there is no access to local community services. The HSV program audiologists will continue to establish partnerships in the private sector.

Enabling Services

HSV will continue distribution of brochures for parents and resource and guideline documents. Hospitals will continue to receive technical support. HSV will improve Early Intervention (EI) access and tracking system for children who are deaf or hard of hearing. This will include training for Part C. HSV will utilize a parent survey to obtain feedback on the entire UNHSI program and to identify barriers and breakdowns in the system. HSV will continue educational efforts for PCP offices to improve reporting of re-screening for infants. HSV and the Advisory Council will revise guideline documents for UNHSI to reflect changes established by the 2007 Joint Committee on Infant Hearing Position Statement. HSV will assess the need for parent brochures in Vietnamese.

Population-Based Services

Emphasis for the coming year will be on hospital technical support and improving the UNHSI follow-up system. Additionally, HSV will maintain the Intervention Services database of children identified with permanent childhood hearing loss (PCHL). The Follow-Up Coordinator will focus on reducing the number of infants lost to follow-up or the lost to documentation.

Infrastructure Building Services

Collaborating with VR and Information Technology (IT) will be a major initiative as VR re-engineers the EBC to implement the new Electronic Birth Registration System. This change will allow HSV to re-design the hearing data collection on the EBC, as well as redesign the hearing data system. Because the UNHSI program will need to integrate the data collection system with VR, the departments will have to work closely to assure compatibility. HSV will finalize an MOU with EarlySteps and the Parent-Pupil Education Program (PPEP) from the Louisiana School for the Deaf, to provide a mechanism for data sharing. This mechanism should ensure that families of children with any type or degree of permanent childhood hearing loss will have a seamless entry from confirmation of hearing loss into EarlySteps and PPEP. PPEP is a statewide outreach which provides parent advisors to assist families to assess, monitor and enhance their child's communication development; and to navigate through systems for identification and intervention. A summary of hospitals' screening technology will be compiled once comprehensive hospital visits are completed.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	14	11	13	7	9
Annual Indicator	15.4	8.2	9.9	16.7	16.7
Numerator	194293	99977	111448	189258	189258
Denominator	1263241	1214001	1121605	1130575	1130575
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9	8	8	8	8

Notes - 2007
Data is provisional and based upon the 2006 data.

Notes - 2006
Estimates are from the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report September 2007.

Notes - 2005
Estimates are from the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report September 2006.

a. Last Year's Accomplishments
In 2006, the percentage of uninsured children from birth to 19 years is 16.7%. This 2006 estimate is from the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Report, September 2007.

The 2006 performance objective of 9% was not reached. Contributing to the increase of uninsured children is the loss of health coverage for almost 68,000 children in greater New Orleans after Hurricane Katrina when their parents lost/changed jobs and/or government-sponsored policies lapsed during evacuation. Also, locating families post-storm for renewal notices of their Medicaid health coverage was difficult. Once uninterrupted coverage for Medicaid children ended in December 2006, enrollees lost Medicaid coverage if they did not return the required paperwork for re-enrollment into the Medicaid Program.
Of note, the percentages of uninsured children under 19 years old in the reports from the Louisiana Health Insurance Surveys (LHIS) are lower than the percentages documented in the AAP, Children's Health Insurance Status Medicaid/SCHIP Eligibility and Enrollment Reports. In the 2003 and 2005 LHIS reports, the percentages of uninsured children are 11.1% and 7.6%, respectively. However, the percentages of uninsured children in 2003 and 2005, according to the AAP, are 15.4% and 9.9%, respectively. In the 2007 LHIS report, the percentage of uninsured children is 5.4%.

Enabling Services

The income eligibility for the state-sponsored health insurance programs were checked for pregnant women, infants, and children attending one of the Office of Public Health's Public Health Units (PHU) for WIC or other health services. Infants and children who were income eligible and

uninsured were provided referral information on LaCHIP/Medicaid and an application. Also, pregnant women who were income eligible LaMOMS/Medicaid were provided applications and referral information. In subsequent visits, those who were still eligible and uninsured were offered additional assistance and another application for the respective programs.

Population-Based Services

The MCH Program continued to work with Covering Kids and Families Initiative in their outreach efforts to enroll eligible children into the state-sponsored health insurance programs (Louisiana State Child Health Insurance Program and Medicaid). The MCH Program Director continued to serve on the Advisory Board while the MCH Child Health Medical Director and MCH Child Health Nurse Coordinator participated in the statewide coalition meetings for the Covering Kids and Families Initiative. The goals of this initiative are to 1) coordinate and conduct outreach, 2) simplify enrollment and renewal processes, and 3) coordinate health coverage programs.

Infrastructure Building Services

The MCH Program maintained a working relationship with the State Medicaid and LaCHIP staff by providing information and technical assistance, particularly in the area of access to services and enrollment. The MCH Program also worked with Medicaid staff to provide updated information regarding services and eligibility criteria to the OPH Public Health Clinics throughout the state. MCH Program staff participated in the State Health Care Reform Initiatives related to health care coverage and access to care.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Eligibility screening for Medicaid/LaCHIP/LaMOM for all infants, children, & pregnant women seen in OPH.		X		
2. Provide Medicaid eligible clients with information on Medicaid and how to apply.		X		
3. Support Covering Kids and Families' outreach efforts.			X	
4. Technical assistance to the LaCHIP, LaMOM, and Medicaid Programs for enrollment eligibility and access to services.				X
5. Monitoring of and participation in Health Care Reform activities related to health care coverage and access to care.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Enabling Services

The OPH clinics continue to screen pregnant women, infants and children, who are seen for WIC or other services, for income eligibility for LaMOMS and LaCHIP/Medicaid. Those who are found income eligible are provided application forms and/or given referral information for application for these programs. Program and enrollment information are available in Spanish and Vietnamese.

Population-Based Services

The MCH Program continues to work with Covering Kids and Families Initiative in support of their outreach activities through the Statewide as well as local coalitions. There are currently 6 regional coalitions located throughout the state. The work of the regional coalitions should help to decrease the regional differences in rates of uninsured children.

Infrastructure Building Services

The MCH Program remains a resource to provide information and technical assistance to the LaCHIP and Medicaid Programs regarding access to services and enrollment. MCH has partnered with LaCHIP to reduce the number of uninsured children by extending enrollment services to eligibles during the Parish Public Health Unit's after-hours clinics in one OPH Region.

c. Plan for the Coming Year
Objective: Decrease the percentage of uninsured children to less than 8%.

Enabling Services

Parish Health Units will continue screening and referral of those uninsured infants, children and adolescents who are eligible for LaCHIP/Medicaid services as well as pregnant women to LaMOMS.

Population-Based Services

The MCH Program will continue to work with Covering Kids and Families in outreach efforts.

Infrastructure Building Services

The MCH Program will continue to work with the Medicaid Program in providing technical assistance and information, particularly in addressing issues of access to service and enrollment eligibility. The MCH Program will continue to support the LaCHIP project to enroll eligibles in the Parish Health Unit After-hours clinics in OPH Region 3.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				12.5	12
Annual Indicator			13.2		
Numerator			11781		
Denominator			89373		
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?					
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	11.5	11	10.5	10.5	10.5

Notes - 2007
The WIC's Program data system has now been in operation since May of 2006 with many problems associated with the application design. Currently, the application developer is working with CDC on the criteria required for data transfer to PedNSS. WIC staff have been assisting with testing the PedNSS application data, and the Program anticipates the renewal of PedNSS participation for federal fiscal year 2009.

Notes - 2006
In May of 2006, the WIC Program implemented a new data system. Due to this major change, data cannot be transferred to the CDC Pediatric Nutrition Surveillance System as done in the past. Therefore, no data can be reported this year.

a. Last Year's Accomplishments
Direct Services
WIC provided services in OPH for counseling and education sessions to families statewide on healthy eating and physical activity. Referrals were made to WIC for specialized nutrition counseling.

Enabling Services
MCH, in collaboration with WIC, participated in the Southwest Regional USDA committee to address childhood obesity. Through this committee, Fit Kids-Healthy Habits flip charts were distributed and utilized in WIC clinics statewide. In addition a series of DVDs entitled "Childhood Nutrition: Preventing Obesity" were distributed to statewide WIC clinics and were played in clinic waiting areas. Furthermore an interactive DVD entitled "Have Fun and Be Active" was distributed to each family seen in a WIC clinic. These DVDs included information on proper nutrition and were used to address childhood obesity.

WIC conducted 6 regional nutrition education conferences for all WIC staff May --August 2007. At these conferences, staff was trained on rapport building for better communication with clients, as well as cultural perspectives on childhood obesity. In addition, in collaboration with the MCH Registered Dietitian, the WIC nutrition educator participated in the MCH Child Health Care Consultants Conference. At this conference, staff was trained on healthy eating for children in the child care setting.

The MCH Registered Dietitian also participated in the Greater New Orleans Association for the Education of Young Children (GNOAEYC) conference. Educators positioned to influence children's diet and behavior were educated on the childhood obesity epidemic, strategies to prevent this problem, and tips on healthy eating and physical activity for school-aged children.

Population Based Services
The 5-A-Day program, now the Fruits and Veggies More Matters program, was promoted at various health fairs around the state. In addition, a farmer's market pilot project was initiated in one region of the state. In this project 300 WIC participants were educated on fruits and vegetables and were given food instruments to redeem at a local farmer's market.

Infrastructure Building Services
The MCH Registered Dietitian (RD) actively participated in the Louisiana Obesity Council, as well as the subgroup, Action for Healthy Kids. In addition the MCH RD participated in the Southwest Regional USDA committee, as well as the State Nutrition Action Plan committee. The Southwest Regional USDA committee is a nutrition integrity workgroup of WIC State Nutrition Coordinators from the USDA Southwest Region. The purpose of this group is to coordinate education messages within the Southwest Region WIC Programs. The State Nutrition Action Plan committee is a workgroup of USDA funded agencies, whose goal is to establish and support partnerships and collaborative interventions between the USDA nutrition assistance programs and other related groups in prevention efforts targeted at overweight and obesity.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Counseling and education sessions to families on healthy eating and physical activity.	X			
2. Referrals to WIC Services for specialized one-on-one nutrition counseling.		X		
3. PHAME software to identify at risk of overweight children.		X		
4. Utilization of educational materials on healthy weight & physical activity for infants and children.		X		
5. Training of health professionals to enhance their abilities to promote healthy lifestyles with patients.				X
6. Participation in the Louisiana Obesity Council and other committees.				X
7. Implementation of guidelines for health professionals on healthy weight and physical activities.		X		
8. Training for health professionals to utilize new methods of nutritional assessment of children age 2 -5.		X		
9. Outreach activities to encourage families to increase consumption of fruits and vegetables.			X	
10.				

b. Current Activities

Infrastructure Building Services

In May 2006 the WIC Program implemented a new data system. Currently this application is being enhanced to meet CDC's criteria for transferring data to The Pediatric Nutrition Surveillance System (PedNSS). Upon completion, data will be transferred from the WIC data system to CDC PedNSS to provide relative data associated with progress in decreasing the number of children age 2 to 5 with a BMI greater than the 85th percentile.

Enabling Services

The MCH RD will participate in the MCH Child Care Health Consultants Conference to train staff on healthy nutrition in the child care setting. The MCH RD will also collaborate with the Coordinator of the Louisiana Obesity Council to provide an in-service to MCH staff on the topic of obesity.

The Coordinator of the Louisiana Obesity Council obtained grant money which will be awarded to the winner of The School Health Award sponsored by the School Health Index program. This program is designed to serve as a tool to help schools assess their physical activity and nutrition policies and programs.

Population Based Services

The WIC education cards were updated and distributed to WIC clinics statewide. These education cards are given to participants to address proper nutrition and feeding techniques. Furthermore the MCH RD actively participates in the MCH education committee. This committee is developing a childhood obesity resource guide to disseminate to staff.

c. Plan for the Coming Year

Objective: Reduce the percent of children (2-5 years old) receiving WIC with a BMI at or above the 85th percentile to 12 %.

Direct Services

WIC will continue to provide services in OPH for counseling and education sessions to families

statewide on healthy eating and physical activity.

Enabling Services
MCH, in collaboration with WIC, will continue to participate in the Southwest Regional USDA committee to address childhood obesity. Through this committee, WIC will purchase 50,000 DVDs and children's books, entitled "A Trip to Bugland" to distribute to WIC families and clinics statewide. These two resources will be used to highlight the importance of healthy nutrition and physical activity in children.

The MCH RD will participate in the GNOAEYC conference. Educators positioned to influence children's diet and behavior will be educated on the childhood obesity epidemic, strategies to prevent this problem, and tips on healthy eating and physical activity for school-aged children.

Statewide training will be conducted with all WIC staff on Value Enhanced Nutrition Assessment October--December 2008. Particular attention will also be paid to training and educating staff and WIC participants on the new WIC food package. The new food package will include reductions in the amount of milk, eggs, cheese and fruit juice and the addition of whole grain bread for children ages 1-5. In addition, children will receive a cash-value voucher for $6.00/month to purchase fruits and vegetables at WIC Vendor sites. Infants will only be able to receive iron-fortified infant formula or breast milk until age 6 months. After 6 months of age, they will begin receiving infant cereal and jarred infant fruit and vegetables. These changes reflect the recommendations by the Institute of Medicine with goals of improving the diets of WIC families. The target date of implementation of the food package changes is October 2009.

Population Based Services
The MCH RD will collaborate with WIC on the State Nutrition Action Plan committee. Through this committee, MCH and WIC will purchase door hangers to disseminate to WIC families, the MCH Child Care Health Consultants, and the nurses of the MCH Nurse Family Partnership program. These door hangers will highlight the messages "Louisiana Seasonal Vegetables" and "Eat Vegetables. Move More" to encourage families to increase their consumption of fruits and vegetables. Education materials will also be disseminated to families around the state to educate them on the new WIC food package rules.

The WIC Farmer's Market project will be introduced in a new region. The goal of this new project will be to increase capacity and to educate more families on the importance of fruits and vegetables.

Infrastructure Building Services
MCH and WIC will continue to actively participate in the Louisiana Obesity Council, Action for Healthy Kids, the Southwest Regional USDA committee, and the State Nutrition Action Plan committee.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				13.8	13.5
Annual Indicator			17.7	17.7	17.7
Numerator			11117	11117	11117
Denominator			62767	62767	62767
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last					

year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	13.5	12.5	13.5	13.5	13.5

Notes - 2007
Data is provisional and based upon 2004 final PRAMS data.

Notes - 2006
Data is provisional and based upon 2004 final PRAMS data.

Notes - 2005
Data is provisional and based upon 2003 final PRAMS data.

a. Last Year's Accomplishments
Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data for 2004 indicated that 17.7% of all pregnant women reported smoking during the last three months of their pregnancy, up from 14.5% in FY 2003. More recent PRAMS data is not available.

Direct Services and Enabling Services
The MCH program in collaboration with Louisiana Section of ACOG, Louisiana Office of Addictive Disorders (OAD), and Office of Mental Health identified a screening tool for tobacco use in pregnancy. This tool, the 4Ps Plus, also screens for substance abuse, alcohol use, depression and domestic violence. State licensure for tool use and data collection from Dr. Ira Chasnoff of the Children's Research Triangle in Chicago was obtained. The tool is being made available to obstetrical providers within the state. OAD funds a regional coordinator in 3 regions of the state, provides treatment resources and coordinates referrals for other treatments. This program is called the Screening, Brief Intervention, Referral and Treatment (SBIRT) Program for Pregnant Women. Three pilot regions (Northshore, Alexandria, Monroe) began services. Baton Rouge continued its SBIRT program.

From initiation of the regional pilot sites in May 2007 through Sept 30, 2007, the SBIRT program in the 3 pilot regions screened 893 pregnant women. Referrals for smoking cessation were made in 126 women. The Baton Rouge project data for 2007 indicated 2828 women screened, with 9.2% smoking since aware of pregnancy; 167 referrals were made to the state Quitline; 91 clients accepted referral.

The contract with the American Cancer Society transitioned to the Louisiana Public Health Institute (LPHI) for Make Yours a Fresh Start Family (MYFSF) a comprehensive smoking cessation program that trained providers in 10 parishes identified as the highest priority. Since 2003, 187 public and 243 private providers have been trained. The intervention consists of initial screening, complete assessment, counseling/educational sessions with prenatal clients found to be tobacco users, and follow-up at all subsequent visits. The MYFSF Smoking Cessation provider training program worked closely with SBIRT to become an active partner in provider offices doing the screening. MYFSF trained providers statewide on the 1800QUITNOW LA quitline/fax referral/pregnancy specific proactive counseling. Since its inception, the MYFSF program screened approximately 18,626 pregnant women, 6322 were counseled to quit.

The Nurse-Family Partnership (NFP) Nurse visitors provide health education on smoking cessation, referrals, and case management to pregnant women/new moms.

Discussion began with Louisiana Medicaid to make SBIRT screening a pay for performance initiative for providers.

Population-Based Services
MCH continued support for Partners for Healthy Babies, a comprehensive helpline and web site for client information on healthy pregnancy, included a focus on smoking cessation in pregnancy. Callers to the Partners helpline can be directly referred to the Louisiana Tobacco Quitline (1-800-QUIT-NOW) and receive information on Great Start, the Perinatal Smoking Cessation Support and Helpline. MCH continued collaborations, support, technical assistance, health information to Healthy Start programs in New Orleans, Lafayette, Baton Rouge, and North Louisiana. MCH continued close collaboration with state March of Dimes CenteringPregnancy programs and for Mom & Baby Mobile Health Vans in New Orleans and Lake Charles. New Orleans MOD van is primarily a Latina population.

Regional Feto-Infant Mortality Review (FIMR) coordinated grants from Office of Minority Health Access, including "Talk Life: Healthy Moms and Healthy Babies" through Alexandria FIMR and partners. Its purpose was to provide tools and information to faith-based groups in the community about the disparity in fetal and infant mortality rates among African Americans. FIMR coordinators continued collaboration with Office of Minority Health Access for April Minority Health Awareness.

Infrastructure
MCH continued a statewide Action Learning Lab (ALL) collaborative to address smoking cessation in women of reproductive age. Partners included Louisiana ACOG, Planned Parenthood, March of Dimes, LPHI and Medicaid. Regional FIMRs identified tobacco use as a risk factor in poor pregnancy outcomes and began strategies for intervention on a community-wide basis. The SBIRT program provided infrastructure for smoking cessation services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide screening and referral for smoking cessation.	X	X		
2. Collaborate with OAD to initiate statewide risk screening.			X	
3. Provide Smoking cessation programs for pregnant women using fax quit lines and direct counseling.		X		
4. Support Partners for Healthy Babies public information campaign for prenatal health.			X	
5. Provide Fetal and Infant Mortality Reduction Initiative in each region of Louisiana.		X		X
6. Provide Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance system.				X
7. Collaborate with Medicaid to promote and reimburse for statewide risk screening /intervention.			X	X
8. Collaborate with LPHI, Planned Parenthood, ACOG, and Medicaid to decrease tobacco use in pregnant women.				X
9. Continue to collaborate with Louisiana Bureau of Minority Affairs to increase awareness of tobacco use, poor birth outcomes and SIDS.				X
10.				

b. Current Activities
Direct and Enabling Services
The 4 regions continue SBIRT services. SBIRT is to start in Lafayette and New Orleans areas in 2008. WIC clinics in Baton Rouge have begun SBIRT screening, reaching many more pregnant women. The SBIRT name is changing to the Louisiana Healthy Babies Initiative (SBIRT-HBI). A fax-referral for hotline assistance and proactive counseling for smoking cessation is available.

Population-Based Services
Two Partners for Healthy Babies (PHB) prenatal care fairs with education materials and presentations were held (Kenner and Slidell). The PHB campaign continues web-based and multimedia approaches.

Infrastructure Building Services
The FIMR Community Action Teams provide local infrastructure to address tobacco use. MCH staff continues education visits to providers and birthing hospitals in all regions. The Tobacco ALL and contract with LPHI for MYFSF is phasing out as HBI will assume the tobacco cessation efforts at the local level. The contract with LPHI will change to a policy focus and hire an MCH coordinator to address MCH concerns, especially tobacco use.

MCH Nurse Consultant and SBIRT Coordinator are conducting Substance Abuse continuing education trainings in SBIRT regions through the AMCHP grant to ALL Collaborative. SBIRT-HBI has hired the former Louisiana
ACOG president as the state Director of SBIRT. Michael Lu, MD, spoke at Annual FIMR 2008 conference on preconception, including tobacco use.

c. Plan for the Coming Year
Objective: Reduce the percent of women who smoke during the third trimester to 13.5%

Direct Services
The SBIRT-HBI program will expand statewide and be utilized in WIC clinics throughout the state. This tool is being provided to all obstetrical providers, and could potentially screen every pregnant woman in the state for tobacco use. Each region will have HBI coordinators and treatment resources. A fax-referral for hotline assistance and proactive counseling for smoking cessation is available. Epidemiological evaluation of the SBIRT-HBI program will begin.

Health units providing prenatal care will continue to screen for smoking and offer brief intervention and referral for cessation services. MCH will work with Family Planning program to expand screening to this population.

Enabling Services
A contract with LPHI for an MCH Coordinator will expand collaboration with their extensive prevention efforts. Regional FIMRs will continue to identify maternal tobacco use in infant and fetal death reviews. Client education materials will continue to be provided through March of Dimes.

The NFP program will continue to address tobacco use during pregnancy, and provide education, counseling and referrals for women in need of these services.

Population-Based Services
The Partners for Healthy Babies program continues to address smoking as a risk factor in pregnancy. State PHB helpline 1800-251-BABY (2229) provides information in Spanish. Client health information is provided in Spanish and English; translation services are provided through language line. LPHI will continue to develop and address smoking prevention media messages (including second hand smoke) for the maternal and child health population. FIMR coordinators continue collaboration with Office of Minority Health Access for April Minority Health Awareness programs among African Americans, faith-based groups, Healthy Start clients, and among Latinas in the New Orleans area.

Infrastructure Building Services
Discussions will continue with Medicaid to reimburse and possibly mandate implementation of

SBIRT screening/intervention. Maternal tobacco use will continue to be addressed by regional FIMRs. Cessation awareness campaigns will continue.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	7.8	7.6	8.8	9.3	8.8
Annual Indicator	9.2	9.6	12.0	12.0	12.0
Numerator	32	33	41	41	41
Denominator	347200	343717	342664	342664	342664
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	8.8	8.8	8.8	8.8	8.8

Notes - 2007
Data is provisional and based upon the 2005 data.

Notes - 2006
Data is provisional and based upon 2005 data.

Notes - 2005
Data is final.

a. Last Year's Accomplishments
Direct Services
The Adolescent School Health Initiative (ASHI) Program, a statewide network of School-Based Health Centers (SBHCs), collaborated with the local mental health authority in region 1, Metropolitan Human Services District (MHSD), to provide mental health counseling and a mechanism for referral. In 2006-07, 5 of the SBHCs had MHSD staff working on site. However, every SBHC has a mental health professional on site to address student's needs. In addition, they each have a formal suicide prevention protocol in place. A statewide uniform encounter form based on ICD-9 codes was implemented in the 1997-98 school year to assist in determining the extent of depression among children at schools with SBHCs and in developing intervention strategies.

The Louisiana Partnership for Youth Suicide Prevention (LPYSP) target youth suicide prevention activities to 10,000 middle, high and college students who are at increased risk of suicidal ideation as a result of Hurricanes Katrina and Rita. This program is the result of a SAMSHA grant to the state for youth suicide prevention activities. The program targets youth ages 10-24 years old of all racial and ethnic groups who lived in the target hurricane-impacted communities, and youth aged 10-18 years old of all racial and ethnic groups evacuated from the target hurricane-impacted communities who currently live in East Baton Rouge Parish, with particular emphasis on

those in FEMA trailer communities.

Over 1,010 individuals participated in Yellow Ribbon Suicide Prevention week by a variety of activities including school based rallies, conferences, and poster and essay contests.

At the largest FEMA trailer community, Columbia University's TeenScreen model was used to screen youth in the Renaissance Village trailer community and at Scottlandville High School in the Baton Rouge area. The screening was conducted on September 28th in partnership with the Children's Coalition of Northeast Louisiana and Harmony Family Outreach Center and was attended by many of the trailer community's resident youth. The program exceeded its objective of screening 150 to 300 at-risk youth in the community by screening 304 youth. Of the 304 youth screened, 41 or 13.5% screened positive for suicide risk and received intervention.
The Louisiana Partnership for Youth Suicide Prevention has been able to reach over 2,139 youth and families with direct services for year 1 of the Garret Lee Smith Suicide Prevention and Early Intervention Program grant.

Infrastructure Building
Gatekeeper training on recognizing suicidal threat and ASIST trainings, (suicide intervention Living Works training curricula) for mental health professionals to intervene, are major components of the LPYSP Initiative and in year 1, the program trained 525 college students, health and mental health professionals, school professionals, and other community representatives. This surpassed the program's objective of training 150 people. In addition, the program has established linkages with 69 diverse agencies and organizations throughout Louisiana, and has engaged a local research firm to design and conduct evaluation activities. Youth Correctional system counselors and mental health personnel received gatekeeper and ASSIST trainings, and a representative of the system is on the Board of Directors. Incarcerated youth also participated in the poster and essay contests.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide mental health counseling and referrals through School-Based Health Centers.	X			
2. Participate as a member of the Louisiana Youth Suicide Prevention Task Force.				X
3. Facilitate youth suicide awareness activities with the Foster Care and Juvenile Justice systems in Louisiana.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services
The Adolescent School Health Initiative Program continues to provide mental health counseling and referral to youth. There are now 69 SBHCs (62 OPH funded) in Louisiana, 14 new centers opened this year. Mental health remains among the top 2 reasons for SBHC visits. The centers collaborate with the regional and district Offices of Mental Health for counseling/referral, and for technical assistance/quality assurance. The Children's Health Fund and ASHI coordinated several workshops for mental health clinicians. This is Year 2 of the Kellogg Foundation $8.7

million dollar grant awarded to Louisiana Public Health Institute (LPHI) for SBHCs in the New Orleans area. These funds are used for facilities construction, clinical services, and expanded mental health services in elementary schools without SBHC's. The Louisiana Partnership for Youth Suicide Prevention held many activities this year: One day print ads ran in major newspapers statewide, with daily circulation from 180,000 to 38,000 readers. Radio PSA's ran for 6 weeks on five radio stations in major markets, with a listenership of half a million. Five Palace Theatres in the New Orleans metropolitan area ran PSA's funded by the AD Council during October.

Infrastructure Building
The first five-day ASIST suicide prevention training and ASIST T4T suicide intervention training were held for 15 trainers, including trainers based in the Youth Correctional system. The new trainers are providing 24 trainings this year.

c. Plan for the Coming Year
Direct Services
As part of the Governor's Health Care Reform efforts, ASHI is collaborating with the Office of Mental Health (OMH), Medicaid and the Department of Education to develop strategies for expanding school-based mental health services. Through the ASHI Program, the SBHCs will continue to collaborate with OMH and the regional offices and districts to provide mental health counseling and referral. ASHI will continue to meet with Medicaid to pursue reimbursement for mental health services provided in SBHCs, none of which are currently being reimbursed. ASHI will continue to partner with Children's Health Fund to provide workshops for mental health providers on best practices in school-based mental health services. It is not known whether additional state funding to plan and subsequently operate additional SBHCs will be allocated during the 2008 Louisiana Legislative Session.

The Louisiana Partnership for Youth Suicide Prevention plans more training in Suicide 101, ASSIST, and ASSIST Trainers for the coming year, along with the annual Yellow Ribbon Week (Youth Suicide Prevention Week) event, which will repeat the successful current year's activities.

Infrastructure Building
The state's LPYSP regional coalitions bolster individual agencies' efforts in the fight against youth suicide. Regional leadership meetings will develop toolkits, resource guides, and school prevention plans that are based on regional culture and needs.

The LPYSP used the Early Identification Referral and Follow-up Form to provide individual level data on youth who have been identified at risk for suicide through Garret Lee Smith Suicide Prevention and Early Intervention Program activities. Youth may be identified by a trained gatekeeper during LPYSP trainings such as Suicide 101, Safe Talk and ASIST Trainings as well as through LPYSP screening activity at local schools such as the Columbia University Teen Screen Program. In addition to these initial referrals, three month follow-up referrals are also made to assess if the youth have attended their mental health services appointment.

The results of the cross-site evaluation tools: Referral Network, Products and Services Inventory, Early Identification, Referral, and Follow-up data in the database will allow the program to refine screening, educational, and intervention efforts. A listserv, will strengthen program linkages, networking, and timely communications.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	85.1	85.2	84.7	84.8	90
Annual Indicator	84.4	86.0	86.8	88.1	88.1
Numerator	1162	1146	1153	1214	1214
Denominator	1376	1333	1328	1378	1378
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	90	90	90	90	90

Notes - 2007
Data is provisional and based upon 2006 data.

Notes - 2006
Calculation of the percent of VLBW births born in Level III facilities requires an accurate list of hospitals with corresponding neonatal facility level codes. This list must be updated periodically as facility levels may change over time. This performance measure will be updated with 2006 data once the current facility level codes have been verified against the current hospital licensure records. It is anticipated that the list of current facility level will be available in August 2008.

Notes - 2005
Calculation of the percent of VLBW births born in Level III facilities requires an accurate list of hospitals with corresponding neonatal facility level codes. This list must be updated periodically as facility levels may change over time. This performance measure will be updated with 2005 data once the current facility level codes have been verified against the current hospital licensure records.

a. Last Year's Accomplishments
The percent of very low birth weight (VLBW) births delivered at high-risk facilities has been steadily increasing. In 2005, 86.8% of such births occurred in the appropriate facility. Preliminary data for 2006 reveals 88.1%

Infrastructure Building Services
The Louisiana Perinatal Commission finalized the revision of the State Perinatal Plan, adopting guidelines to reflect a concordance in level between obstetrical and neonatal services, i.e. for a neonatal Level III facility, obstetrical services should be of Level III as well. The regulatory approval of the revised plan was delayed in 2006 due to public comment. The Louisiana Office of Public Health (OPH) continued to provide epidemiological data analysis updates through presentations at Louisiana Perinatal Commission and regional Feto-Infant Mortality Review (FIMR) meetings. The MCH Program Director and the MCH Maternity Medical Director, as members of the Perinatal Commission, and the MCH Epidemiology (EPI) group, served as a resource for data and information to the Perinatal Commission regarding VLBW and other relevant MCH issues. The EPI group study on VLBW deliveries by level of delivery hospital was presented at regional and national meetings. Louisiana was one of the State Infant Mortality Collaborative (SIMC) states and this information has been disseminated.

The lead MCH epidemiologist, Maternity Medical Director, and Maternity Nurse Coordinator, continued to provide coordination and shape to the Fetal Infant Mortality Reduction Initiative in 2006-07 through regional FIMR meetings and the fifth annual statewide Louisiana FIMR network

meeting. During 2006-07, the Louisiana FIMR network reviewed perinatal deaths in seven of the nine administrative regions to help identify important issues surrounding these deaths. The New Orleans area FIMR was not functional due to lack of infrastructure after Hurricane Katrina. While the FIMR groups are evaluating contributors to fetal and infant deaths, their work focuses heavily on the high preterm births and VLBW issues in our state.

A Screening, Brief Intervention, Referral and Treatment (SBIRT) program was developed, and is in place in 4 regions, in conjunction with other state partners to screen/ treat pregnant women for substance use, tobacco use, alcohol use, depression, and domestic violence. The tool for this program is the 4Ps Plus developed by the National Children's Triangle of Chicago. The state group implementing the program is MCH, Louisiana Section of American College of Obstetricians and Gynecologists (ACOG), state Office of Addictive Disorders (OAD), and state Office of Mental Health (OMH). The MCH Epidemiology group provided technical assistance on development of an evaluation plan. It is hoped that with improved screening and treatment, VLBW births may decrease.

Perinatal Periods of Risk methodology, an analysis of infant mortality according to birth weight and age at death, was an important component of the analyses presented to assist with the needs assessment. Data indicated that VLBW births accounted for nearly half of the total feto-infant mortality rate, indicating that VLBW births and prematurity are important factors for Louisiana.

MCH provided technical assistance in development of CenteringPregnancy groups, which may help address prematurity and VLBW. MCH supported development by March of Dimes (MOD) to place mobile maternity clinics in hurricane affected southern Louisiana.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Study distribution of VLBW infants born at all levels in the state, by region & parish.				X
2. Perform multivariate analysis of risk factors associated with mortality by hospital level and birth weight.				X
3. Update electronic MCH Data Book.				X
4. Support MCH grants for the perinatal mortality reduction initiative.				X
5. Support and promote regional Feto-Infant Mortality Reviews (FIMRs).				X
6. Support existing and develop additional regional MCH Forums.				X
7. Disseminate analysis findings to all regional FIMRs and Perinatal Commission.				X
8. Increase collaboration with March of Dimes and other community based groups through FIMRs.				X
9.				
10.				

b. Current Activities

Infrastructure Building Services

The revised State Perinatal Plan received regulatory approval, linking maternal and neonatal levels of care. MCH continues to work with the Commission in monitoring VLBW births.

MCH continues to support the regional FIMR groups. The Baton Rouge group has been

restructured and new staff hired. A coordinator has been hired in the New Orleans area, and is beginning reviews. The FIMR review teams regularly provide recommendations to the Community Action Teams (CATs). The CATs continue to support measures to decrease the number of VLBW births and to increase the VLBW infants being born at facilities with the proper level of care. With African Americans having a significant disparity in VLBW births, this disparity is being targeted throughout the state.

The provider based SBIRT screening / treatment program for pregnant women started in 3 regions, continued in the Baton Rouge, is expanding in 2 more regions, Lafayette and New Orleans. WIC clinics throughout the state are in the planning phase to implement screening. Medicaid is considering beginning reimbursement for utilization of SBIRT screening / intervention in pregnancy. The 6th Annual FIMR Conference focus was preconception and interconception care and its importance in prevention of prematurity. MCH supports the CenteringPregnancy groups, to help address prematurity and VLBW. MCH assists with the MOD funded prenatal mobile vans that provide care, especially in the New Orleans area.

c. Plan for the Coming Year

Objective: The proportion of very low birth weight infants delivered at facilities for high-risk deliveries and neonates will be at least 90%.

Infrastructure Building Services

Updates to the regional FIMR groups on risk factors associated with VLBW births at lower level facilities will occur and additional vital statistics analyses will continue to be performed. Data including records after the hurricanes will be analyzed to look at the regional distribution of VLBW infants born at various hospital levels.

The complete impact of facility closures due to Hurricanes Katrina and Rita, on the percent of VLBW births delivered at Level III facilities, continues to be unknown. MCH epidemiology will monitor and report findings of analyses as more post-hurricane data become available.

Regional FIMR groups will continue to monitor factors associated with VLBW deaths through case reviews. Opportunity for community action where appropriate will be carried out through FIMR CATs.

The provider based SBIRT screening / treatment program for pregnant women, now named the Healthy Baby Initiative (HBI), will be expanded to all regions of the state. WIC clinics will also initiate screening. With OAD assistance, regional coordinators will be in place in all regions of the state to assist providers in brief interventions, referrals and treatment. Each region will have a resource guide for referrals and treatment, which is being made available to all interested providers. Plans are in place to evaluate SBIRT program effectiveness. Discussions are ongoing with state Medicaid for reimbursement for utilization of SBIRT screening in pregnancy.

The OPH maternity program, in collaboration with regional FIMRs, will continue to refine disaster plans that are in place for pregnant women and newborns. This includes plans for evacuation of inpatients and care for evacuees that may be pregnant. The Partners for Healthy Babies hotline is monitored and updated to provide accurate regional information.

MCH anticipates further strengthening of collaborations. This includes March of Dimes, CenteringPregnancy groups, mobile prenatal vans, other state agencies, provider groups, as well as other community based organizations through. Through these collaborations, we hope to have a greater impact on the many factors that contribute to VLBW births, and where these births occur.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	83.6	84.5	85	86	87
Annual Indicator	84.1	85.5	87.1	87.1	87.1
Numerator	54305	55383	52290	54193	54193
Denominator	64545	64770	60058	62214	62214
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	88	89	90	91	91

Notes - 2007
Data is provisional and based upon the 2006 data.

Notes - 2006
Data is provisional.

Notes - 2005
Data is final.

a. Last Year's Accomplishments
Early prenatal care has increased from 82.3% in 1998 to 87.1% in 2005. Louisiana ranks favorably among all the states. The preliminary 2006 rate is 87.1%

Direct Services
Comprehensive prenatal care services were provided to 1,790 pregnant women through 30,139 visits via the statewide network of parish health units. Over 14,774 pregnancy tests were performed. WIC benefits and health education were provided to 49,300 women through the parish health units. In medically underserved areas, contractors provided prenatal services to 479 low- income women, with approximately 2,703 visits.

MCH collaborated with the March of Dimes (MOD) to begin prenatal care by mobile health vans in southern Louisiana. Over 200 women received prenatal care on the mobile units, to primarily a hard to reach populations. Collaboration with MOD also resulted in CenteringPregnancy groups in Monroe and New Orleans regions.

MCH works closely with Medicaid to enhance access to early and comprehensive prenatal care. MCH played an important role in Medicaid prenatal coverage of undocumented residents under the LaCHIP program.

Enabling Services
The Nurse Family Partnership (NFP) provided home visits and case management to 1,725 first-time mothers for a total of 15,912 visits. Home visits are provided during pregnancy and continue until the child's second birthday.

MCH funded an outreach/case management program in the Northeast Louisiana Healthy Start program that provided services to 60 pregnant women. MCH provided funding to Baton Rouge Healthy Start, which provided prenatal support and educational services to 3,829 clients, with 2,046 home visits, and 1,532 referrals to community agencies.

Population-Based Services
The Partners for Healthy Babies (PHB) social marketing campaign developed messages to further brand the campaign and promote the helpline, PHB website, oral health and prenatal care. Formative research was conducted to assure that the project remain culturally sensitive and competent. The Helpline received approximately 7311 calls in FY 2007. The PHB website received 18,399 webvisits, 15,074 unique visitors and 45,830 pageviews in CY 2007.

Infrastructure Building Services
Technical assistance was provided in all regions participating in prenatal services. All sites were found to provide adequate services; problematic issues were addressed through follow-up. Parishes in the lowest quartile for late entry and inadequate prenatal care were identified. This information was provided to regional Infant Mortality Reduction Initiative coordinators and utilized in ongoing regional needs assessment and strategic planning. Post-Hurricanes, access to prenatal care worsened in southern Louisiana due to the many obstetrical providers that left the hurricane affected areas. Since Hurricane Katrina, there has been a significant influx of Hispanics into the New Orleans area. Access to care for this group of Latina women has proven difficult due to lack of providers, lack of funding source for prenatal care, and the lack of a bilingual medical culture. MCH played an important role in Medicaid prenatal coverage of undocumented residents under the LaCHIP program.

Working with the March of Dimes, funding was secured to begin Centering Pregnancy programs in the state. This will be especially important in the New Orleans area, where bilingual provider staff has been secured. MCH has also been working with the March of Dimes to place mobile clinics in southern Louisiana to provide prenatal care. These are being targeted at areas that remain with poor infrastructure since the hurricanes.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of prenatal services via network of parish health units and contract agencies.	X			
2. Provide targeted case management programs, such as Nurse Family Partnership.		X		
3. Link women to prenatal care via the Partners for Healthy Babies social marketing project Helpline.			X	
4. Collect and analyze PRAMS data to provide program direction.				X
5. Provide Quality Assurance and program monitoring of all MCH funded prenatal services.				X
6. Develop Regional Infant Mortality Reduction infrastructure, at each regional level, using Coordinators.				X
7. Work with Medicaid to ensure access to early and comprehensive prenatal care services.				X
8.				
9.				
10.				

b. Current Activities

Direct and Enabling Services

In regions with provider shortages, MCH provides services through the PHUs and contract agencies. NFP continues to provide case management and home visiting. Prenatal clinics, outreach and case management are ongoing in Shreveport, Baton Rouge, and New Orleans with MCH support.

Population-Based Services

PHB continues to use a mix of communication strategies. The updated 24 hour Hotline and website continues, as does the newsletter. The importance of early and adequate prenatal care is stressed by PHB. Prenatal Care Health Fairs were held in New Orleans (2006), and Slidell (2007). A post-disaster needs assessment was piloted in the Slidell event.

Infrastructure Building Services

The hurricanes devastated the healthcare infrastructure in South Louisiana. Orleans Parish lost all prenatal care services for the indigent population, with University Hospital and PHU only recently reopening. Efforts to reestablish prenatal care sites in South Louisiana are ongoing, including utilizing mobile health services. Orleans Parish public health unit is now reopened and provides prenatal care.

c. Plan for the Coming Year

Objective: Increase the proportion of infants born to pregnant women receiving prenatal care beginning in the first trimester to 89%.

Direct Services

In areas with poor infrastructure, MCH will continue to support access to care through PHUs, contracts, and Healthy Start initiatives. Parishes in the lowest quartile for late and inadequate prenatal care will continue to be identified. Regional IMRI Community Action Teams will be alerted so that public and private providers can work together to improve entry to prenatal care.

Enabling Services

NFP teams continue to provide services and are expected to expand within the next year. Perinatal depression services are provided in the New Orleans area through a HRSA grant.

Population-Based Services

Partners for Healthy Babies (PHB) will continue to work in conjunction with the state maternity medical director to reach out to high-risk areas of the state, including the private provider community and conduct extensive media messaging, public relations, and other activities in these areas. Continued coordination is planned with the LaMOMS program to provide outreach to, and recruitment of pregnant women. PHB will train and support the regional FIMR Coordinators in public relations efforts/activities.

Infrastructure Building Services

The Louisiana Fetal and Infant Mortality Reduction Initiative (FIMR) Community Action Teams (CATs) are being encouraged to expand their role to serve as umbrella organization for MCH issues. Regional FIMRs are expanding focus on disparity, prematurity, and infant mortality in strategic planning for the CATs. Hurricane Katrina will continue to result in greater attention for rebuilding infrastructure in the New Orleans area. The Maternity Medical Director and Nurse Consultant are continuing the statewide visits to providers and hospitals of high-risk obstetrical populations.

The SBIRT program, now named the Healthy Baby Initiative (HBI), providing screening and treatment for women with substance abuse problems, depression, and domestic violence will

expand, in conjunction with other state partners. Access to early care is important in identification/treatment of substance use. Collaboration with Medicaid includes substance abuse screening, smoking cessation, and periodontal care in pregnancy and incentives for entry into early prenatal care.

Continued collaboration with Partners for Healthy Babies will target both patients and providers on the need for early entry into care. Parishes with poor performance on early and adequate prenatal care will be identified, and given targeted technical assistance.

MCH will continue to monitor quality assurance systems at all levels. PRAMS data is being analyzed and the final report will be widely distributed to stakeholders and made available through the Internet.

D. State Performance Measures

State Performance Measure 1: *Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	6.9	6.9	6.9	7.1	7.3
Annual Indicator	6.9	7.0	6.7	7.4	7.3
Numerator	48494	49464	46868	45305	49454
Denominator	706119	704129	700534	612468	681753
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	7.5	7.7	8	8	8.3

a. Last Year's Accomplishments

The number of students with access to a school-based health center (SBHC) was 7.3% of the approximate 681,753 students enrolled in public schools. The Adolescent School Health Initiative (ASHI) met its goal of 7.3% of students enrolled. The number of students with access increased but the percentage with access decreased because the number of students in public schools increased 1 year after Hurricanes Katrina and Rita. There were 52 state-funded, 1 federally funded and 3 privately funded SBHCs.

Direct Services

An additional $1.6 million was appropriated by the State Legislature for 2006-07, which funded 9 SBHC planning grants & an 8% increases in existing SBHC contracts. Kellogg Foundation awarded Louisiana Public Health Institute (LPHI) a 3 year, $8.7 million grant for SBHCs in the greater New Orleans. During year 1, grant dollars were used for facility development, expanded mental health services, additional medical services, planning for an electronic medical record (EMR), and 1 SBHC planning grant.

The OPH New Orleans Lab remained closed. In March 2007, LSU began performing urine gonorrhea/chlamydia testing for SBHCs so that sites could resume screening for STDs. SBHCs continue to screen high-risk students for Type 2 diabetes. Of 1151 screens performed, 1.8% of tests were positive. All children with positive tests were referred for further evaluation and management.

Infrastructure Building Services

Eight SBHC sponsors underwent a Continuous Quality Improvement (CQI) review. A newer CQI

tool, based on the National Assembly on SBHCs' tool, was utilized for 7 of the 8 reviews. It focuses on core sentinel conditions, such as comprehensive physical exams, immunization rates, asthma management, data management, academic achievement, and health insurance enrollment.

ASHI continued its Best Practices Initiative, coordinating educational workshops for SBHC staff on national best practices. The Type 2 Diabetes and the STD Best Practices were updated based on national guidelines. ASHI conducted TA workshops and conference calls for planning grantees. In partnership with the Children's Health Fund, ASHI coordinated a series of 4 regional workshops & peer consultation groups for mental health professionals on evidence based interventions. There were 357 total participants for the series of workshops. ASHI, in collaboration with the Louisiana Primary Care Association and the Bureau of Primary Care and Rural Health, conducted a workshop on enhancing SBHC revenues with 23 SBHC staff participating.

The Legislature appropriated $2.9 million to Louisiana Medicaid to reimburse for mental health in SBHCs pending CMS approval. Nearly all of the SBHCs are LaCHIP/Medicaid application centers. Through LaCHIP outreach efforts, SBHC staff decreased the percentage of uninsured students enrolled in SBHCs from 9% in 2005-06 to 8% in 2006-2007. Documentation of up-to-date immunization determined by random chart audits increased from 51% at the beginning of the school year to 75% by the end of the school year.

ASHI continued to collaborate with the state Department of Education (DOE) on school health related initiatives. This included implementation of coordinated school health and the promulgation of rules and regulations for the implementation of standardized school health forms.

An attachment is included in this section.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. SBHCs provide comprehensive preventive and primary physical and mental health services.	X	X		
2. Set policies and standards for SBHC operation.				X
3. Provide technical assistance, monitoring, continuous quality improvement in SBHCs.	X			X
4. Work to raise level of funding to support SBHC operation.				X
5. Publish Louisiana School-Based Health Centers Annual Services Report.				X
6. Collaborate with various entities to promote coordinated school health model.				X
7. Provide resources to policy makers, educators, service providers, etc. on school health issues.				X
8. Generate statistical reports on service delivery in Louisiana SBHCs.				X
9.				
10.				

b. Current Activities

Direct Services

ASHI funds, provides technical assistance & monitors SBHCs. An additional $855,284 for planning grant sites to become operational was appropriated with 14 new SBHCs opening, including 10 state-funded, 1 foundation-funded, and 3 community clinics on school campuses. There are now 69 SBHCs. The New Orleans Recovery School District was appropriated $1.2

million for SBHCs.

During year 2 of the Kellogg grant, LPHI is funding facility construction, mental health expansion, operational costs of 1 SBHC, and planning for an Emergency Medical Record (EMR). RWJF awarded LPHI a multi-year grant for the implementation of an EMR in the greater New Orleans SBHCs.

Infrastructure Building Services
Louisiana Medicaid continues to await CMS approval to reimburse for mental health in SBHCs. A workshop for SBHCs on billing private insurance is planned.

SBHCs in 7 locations will undergo on-site CQI review. ASHI conducted workshops & conference calls for new SBHCs. With Children's Health Fund, ASHI continued the series of regional mental health workshops.

ASHI collaborates with DOE on school health related initiatives, including standardized health forms and school-based mental health. In collaboration with Medicaid, University of Louisiana at Monroe, & LPHI, ASHI is submitting an IRB to study claims data of asthmatics with access to a SBHC comparing to those without. An HIV Best Practice is being developed.

c. Plan for the Coming Year
Objective: Increase the percent of all children and adolescents enrolled in public schools that have access to school-based health centers to 7.7%.

During the 2008 Legislative Session, OPH is requesting funds for additional planning grants. ASHI will continue to work closely with LPHI, which is funding SBHC operation, information technology and facility development in the greater New Orleans area. ASHI will continue to work with Louisiana Medicaid in developing the process for reimbursement of mental health services in SBHCs.

Direct Services
The ASHI Program will continue to fund, provide technical assistance, and monitor the state-funded SBHCs. Current services provided will continue to be available to students served by SBHCs. STD testing onsite will be required of all SBHCs serving 9th graders and older.

Infrastructure Building Services
The MCH Needs Assessment process found mental health, substance abuse, and access to health care to be the top three priority needs of adolescents. In response to these needs and as a result of the hurricanes, OPH-ASHI will continue to work with Medicaid and the Offices of Mental Health and Addictive Disorders to develop strategies to expand school-based mental health and substance abuse services. ASHI will also continue to work with Medicaid to provide for SBHC Medicaid reimbursement for mental health services.

ASHI will continue to use the new outcome based CQI tool on SBHC site visits and to collaborate with DOE and other agencies to promote and support coordinated school health programming.

State Performance Measure 2: *Percent of women in need of family planning services who have received such services.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2003	2004	2005	2006	2007

Data					
Annual Performance Objective	23	23.5	24	24.5	25
Annual Indicator	23.8	25.4	20.4	17.7	18.8
Numerator	74885	77228	62142	53975	57124
Denominator	314000	304270	304270	304270	304270
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	24.5	25	25.5	26	26.5

Notes - 2007
Data is for the calendar year.

Notes - 2006
Data is for the calendar year.

Notes - 2005
Data is for the calendar year.

a. Last Year's Accomplishments
In 2007, 57,124 clients received comprehensive reproductive health care services through the Family Planning Program (FPP) compared to 53,975 clients in 2006. This figure represents 18.7% of the estimated 304,270 women in need of publicly funded family planning services in Louisiana, up one percent from the prior year, but down considerably from pre-hurricane Katrina 2004 when 77,228 clients were served reaching 25.4% of women in need of services. An estimated eighty-eight percent of clients receiving such services were at 100% of the federal poverty level or below.

Direct Services
The Office of Public Health (OPH) Family Planning Program (FPP) received supplemental funding from Title V and provided comprehensive medical, educational, nutritional, psychosocial, and reproductive health care services to women and men. The FPP provide services in 68 state-administered facilities and 8 contract sites.

Enabling Services
The Louisiana Department of Health and Hospitals received a Research and Demonstration Waiver under Section 1115 of the Social Security Act to expand eligibility for Family Planning services to women ages 19-44, with family incomes up to 200% of the federal poverty level. The Family Planning Waiver program, entitled Take Charge, includes the women losing Medicaid eligibility after their pregnant woman certification ends.

The FPP increased utilization of services by the women most in need through targeted outreach and education activities. The activities consisted of individual and small group reproductive health education, counseling and referral to services. Coordinators were recruited and hired for each region to facilitate outreach activities to women 19-44 for Take Charge Family Planning Waiver Program. As of September 2007, approximately 31,318 women were approved for the Waiver Program.

Infrastructure Building Services
Ongoing preventive health trainings were conducted on both regional and statewide levels reaching a large audience representing the range of health care providers. The FPP conducts training activities by working collaboratively with the Center for Health Training who serves as our federal Region VI Training Center.

The Mystery Caller Quality Assurance Study was conducted again to assess the need of availability of services for the women in need of Family Planning services. The Mystery Caller

Study has been effective in identifying the level of need for Family Planning services.

Population Based
Outreach and education activities included the distribution of educational materials. A variety of regional and statewide trainings were conducted for the providers. Contractors were invited and encouraged to participate in all training activities.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provision of family planning services throughout the state in over 69 sites.	X	X		
2. Improving efficiency and quality of care in state-run and contract service sites.				X
3. Provision of community outreach and education to women in need of family planning services.		X		
4. Training of family planning service providers on topics that enhance family planning services.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Direct Services
The FPP continues to increase the ability to serve women in need of family planning services. Currently, there are 69 state-administered facilities and 8 contract sites. The FPP also continues to identify providers who are able to provide services during evening and Saturday hours and in areas most in need.

Enabling Services
The FPP actively participates in the Family Planning Waiver Program, entitled Take Charge. Activities focus on individual and small group reproductive health education, counseling and referral to services. Coordinators from each region facilitate outreach activities to women 19-44. Currently, 53,383 applications were approved for the Medicaid Waiver Program.

Infrastructure Building Services
The FPP promotes training activities by working collaboratively with the Center for Health Training. Training topics offered include pre-conception care counseling and family involvement in reproductive health. The FPP also promotes folic acid for women of childbearing age to help prevent neural tube defects.

Population Based
New Orleans region nurses enrolled in a Spanish course to better serve the increasing Hispanic population, arriving to help with the rebuilding of New Orleans. Cultural competency, outreach and education are provided continuously to make the clinic environment culturally accessible and improve service to the changing population.

c. Plan for the Coming Year

Objective: Increase to 20% the proportion of women in need of family planning services who have received such services.

Direct Services
To increase the FPP's ability to serve the women in need of family planning services, contract services sites will continue to be added or expanded. Contractors with the ability to service the culturally changing environment and volume of those most in need of FP services will be given top priority to receive FP services.

Enabling Services
The Family Planning Waiver program, entitled Take Charge, help increase the FPP's ability to serve the women in need of family planning services. Coordinators will work in the parish health units and participate in community outreach programs to enroll women in the Take Charge Waiver Program. Meetings with Medicaid and Community Coalitions will be held to reach eligible women.

Infrastructure Building Services
The FPP will continue promoting training activities by working collaboratively with the Center for Health Training. The Training Center will continue to offer trainings on pre-conception care counseling and family involvement in reproductive health. In addition, training topics such as New and Emerging Methods of Contraception and Screening for and Preventing Intimate Partner Violence will also be offered. FPP will continue these training activities to improve the quality of care while also increasing the program's capacity to provide services.

The FPP will continue promoting folic acid to ensure that all women of childbearing age get enough folic acid before pregnancy to help prevent birth defects. Women's health needs will continue to be a priority in family planning clinics.

Population Based
Due to the constant growth of the Hispanic population, it is imperative that outreach and education will be provided to make the clinic environment culturally accessible and better service the changing population. Activities will continue to focus on the culturally changing population, which will include individual and small group reproductive health education, counseling and referral to services.

State Performance Measure 3: *Rate of children (per 1,000) under 18 who have been abused or neglected.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	8.2	7.7	7.6	8.7	9
Annual Indicator	8.8	9.3	9.2	9.2	9.0
Numerator	10744	10832	10815	10525	10360
Denominator	1224027	1169276	1169276	1147652	1147652
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	9	9	8.9	8.8	8.7

Notes - 2007
Numerator is based on Office of Community Services reports of unduplicated number of children 17 years of age and younger who experienced abuse and neglect, CY 2007. Denominator is the number of children in Louisiana ages 0-17 years, using July 2005 census data.

Notes - 2006
Numerator is based on Office of Community Services reports of unduplicated number of children 17 years of age and younger who experienced abuse and neglect, CY 2006. Denominator is the number of children in Louisiana ages 0-17 years, using July 2005 census data.

Notes - 2005
The denominator is based upon 2004 data. Data is for the calendar year.

a. Last Year's Accomplishments
During 2007, there were 18,994 validated allegations of abuse and neglect in children under age 18. The unduplicated count of 10,360 victims yields a rate of 9.0 victims per 1,000 children, a small decrease from last year.

Direct Services
Public health staff provide parenting education materials and counseling to families. Public Health Nurses (PHNs) assisted the Office of Community Services (OCS) case workers with health assessments of children suspected of medical neglect from families under investigation. PHN's assessed the health status of five (5) children suspected of medical neglect.

MCH contracted with Children's Bureau of New Orleans to provide clinical grief/trauma assessments, home, school-based, family and group therapy, and crisis intervention services. Between October 2006 and September 2007, Project LAST provided services to 180 new families impacted by homicide, other violence, Katrina-related traumas, and other sudden unexpected infant deaths (272 adults and 156 child-clients).

Enabling Services
Between October 2006 and September 2007, the Nurse-Family Partnership (NFP) program added a partial team in Region 1, New Orleans. This team is funded by a grant from local foundation, Institute of Mental Hygiene, to the LSUHSC Department of Pediatrics. Three nurses were hired and began to see clients. The 13 NFP teams served a total of 2939 mothers in 29 parishes. Clinical trials and longitudinal studies show NFP significantly reduces validated child abuse and neglect.

The Best Start offered small group and home based interventions by a mental health clinician and nurse to pregnant women and women with infants in Region 5. A total of 220 women and infants €received services, including post Katrina information.

Population-Based Services
Approximately 88,942 Happy and Healthy Kids parenting newsletters were distributed to parents via parish health units, birthing hospitals, health fairs, and vital records complimentary birth certificates. This newsletter has 28 issues sent to parents of children ages 0 to 5 years old. A system to monitor distribution efforts through vendor reports, newsletter addendum, and annual reports was developed. Partners for Healthy Babies website became a main source for subscribers to sign-up for the newsletter via the internet.

Infrastructure Building Services
Thirty three PHNs, social workers, and other professionals were trained in infant mental health (IMH). This 36-hour curriculum provides information and skills regarding early social-emotional development and parenting to improve identification of risk factors for child abuse and neglect. Focus includes cultural and ethnic influences on parenting. Availability of this program was extended to other state programs that serve infants and young children, including Early Steps, child protection, and Early Childhood Supports and Services (ECSS). In addition, over 50 PHN's were trained in post-hurricane child care consultation, 75 mental health providers in the Lake Charles area on Infant Mental Health, and 80 NFP nurses were trained on working with adolescent parents, as well as perinatal loss, including cultural differences in responses. Twenty-

five Healthy Start health advocates were trained on perinatal depression, 20 attendees participated in a statewide video conference on perinatal depression, and another statewide videoconference was held on unique aspects of grief in Sudden Unexplained Infant Death (SUID).

In 2007, the State and the local Child Death Review Panels (CDRP) conducted 18 CDRP meetings, and 89 unexpected deaths of children under the age of 15 were reviewed. Also reviewed at the state level were 99 sudden unexplained infant deaths (SUIDS). The MCH Child Safety Coordinators continued to serve as the local CDRP coordinators to implement effective injury prevention interventions from the panels' recommendations to prevent future deaths.

The Oral Health Program monitored the number of abuse and neglect cases reported by dental professionals; there were twenty abuse and/or neglect cases in FY 2007; eight cases were validated, eleven were not validated, and one case is pending.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Health Record psychosocial assessment for children 0-6 in health units.	X			
2. Home visitation services for low-income families.		X		
3. Infant mental health services to low-income families through Best Start and NFP programs.		X		
4. Statewide infant mental health training to public health nurses.				X
5. Collection, analysis, and assessment of unexpected child deaths by the Child Death Review Panel.				X
6. Monitoring of child abuse and neglect referrals by dental professionals.				X
7. Public education through new parent's newsletter, Happy and Healthy Kids.				X
8. Targeted psycho-educational services for at-risk mothers.			X	
9. Targeted psycho-educational and support services for at-risk children and their families.		X		
10.				

b. Current Activities

Population-based services

There were 2,396 new subscribers for Happy and Healthy Kids newsletter from October 2007 thru June 2008. Happy and Healthy Kids began an evaluation of distribution efforts.

Direct Services

Children's Bureau's provided services to 84 new families who experienced trauma reactions/symptoms due to Hurricane Katrina and other events, including those who experienced infant death from SUID.

Enabling Services

The NFP program added two new teams, one each in Region 6 and Region 7 and expanded the Jefferson and St. Tammany Parish programs to full teams. The program served 2835 families in 41 parishes. The Best Start program served 98 pregnant women and women with infants. Mental health consultation was provided to 8 nurses in two NFP sites. Over 60 women and infants with perinatal depression received services through the Perinatal Depression Program in Region 1.

Infrastructure Building Services

Over 78 nurses, social workers, and case managers received the 36-hour Infant Mental Health training. An additional 50 public health social workers, 123 Head Start staff received an overview of infant mental health. Training on child care consultation was provided, and members of the police and Region 1 crisis team members received training on perinatal depression. Trainings to Orleans Parish Healthy Start staff included perinatal depression, infant mental health, client comfort, and the use of the Edinburgh Postnatal Depression Scale.

c. Plan for the Coming Year

Objective: To reduce the rate of children (per 1,000) under 18 who have been abused or neglected to 8.6.

Direct Services and Enabling Services

Expansion of the NFP services in Region 2 and Region 9 is planned for the coming year. Currently, 7 of the 9 regions have Medicaid funding; DSS-TANF also is providing funding for NFP, and MCH-OPH is working closely with Medicaid and TANF to ensure coverage. Grant support and legislative advocacy for state general funds are being pursued by community entities to further strengthen and expand NFP. The Best Start program will continue to serve Region 5. The Perinatal Depression Program in Region 1 will offer services to pregnant women and women with infants with perinatal depression or other mental health needs in three locations in the metropolitan area. Grief/trauma services to children and families in Orleans and Jefferson Parish will be provided via the Children's Bureau's Project Last program. Children's Bureau also provides education and support to families who experience SUID or other unexpected infant deaths.

Population-Based Services

MCH will continue to distribute the multicultural parenting newsletter, Happy and Healthy Kids. Issues of the newsletter will continue to be distributed through public health units, provider offices, health fairs, and with the complimentary birth certificate provided to families by Vital Records. Over 50,000 Louisiana families are anticipated to receive the newsletter this year. A feasibility study on an e-newsletter version of the parenting newsletter, in addition to an impact evaluation, are planned.

The Oral Health Program will educate oral health professionals on reporting abuse and neglect through the Louisiana Dental Association Journal and the Louisiana Dental Hygiene Association Newsletter.

Infrastructure Building Services

Infant Mental Health trainings will be offered bi-annually. In addition, introductory trainings on infant mental health and maternal depression will be provided to other state and nonprofit agencies, especially those providing services to the hurricane affected areas of the state. The purpose is to increase awareness of these issues and facilitate appropriate referrals. Culture-specific issues are addressed in these trainings.

The State Child Death Review will: continue reviews of child deaths under 15 years of age, including sudden unexplained infant deaths; support the local CDR panels; initiate new and improve current injury prevention interventions at the state and local levels; implement the CDC web-based case reporting system; provide trainings on effective infant and child death investigations to CDRP and FIMR coordinators, coroners/medical examiners, death scene investigators, physicians, nurses, first responders, and others involved in the investigative process.

State Performance Measure 4: *Percent of CSHS patients with case management (follow-up visits) from a nurse, social worker, or nutritionist.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	52	55	57	64	66
Annual Indicator	53.2	51.5	62.8	81.6	72.6
Numerator	3041	2760	3287	3965	3370
Denominator	5711	5363	5236	4858	4645
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	85	85	85	85	85

a. Last Year's Accomplishments
During the past year, 72.6 % of CSHCN in CSHS clinics received follow-up services from a nurse, social worker or nutritionist, as documented in the data system. This follow-up % was a decrease from last year's report of 82.6%. The annual performance objective was 85 %. Follow-up data is obtained from the Compass billing system after services are provided. During this reporting period, shortages of staff and the burden of having to use many data systems to record information resulted in follow-up encounters not uniformly coded in the Compass system. In addition, one region of the state did not have social services staff.

Direct and Enabling Services
In each of the 9 regions of the state, CSHS staff provided follow-up services to CSHCN and their families in CSHS direct service clinics and some private clinics where CSHS funded services were obtained. One region of the state continued the pilot care coordination program for CYSHCN with intensive needs as identified in a Family Needs Assessment. These follow-up services linked families to appropriate services in their communities as determined through clinical assessments or the medical treatment plan. Children ages 14 -- 16 were also screened for transition service needs, with staff providing services for all identified needs. Staff linked 98.9% of CYSHCN who attended clinics to Medical Homes. Staff in several regions continued to assist families that had located out of state after Hurricanes Katrina and Rita. As families returned to their homes in the hurricane affected areas, staff worked to make linkages to all needed services. An analysis of CYSHCN who received CSHS follow-up services showed that there was no difference in follow-up services provided by race or ethnicity. By age, a larger percentage of follow-up services were provided in the 12-17 age group. By clinic type, the highest % of follow-up services were provided to CYSHCN in neurology and orthopedic clinics. The Parent Liaison staff of 12 was able to connect with families in many diverse ethnicities in CSHS clinics. This staff included 2 Hispanic/Spanish speaking, 1 Vietnamese, 4 African American and 1 Cajun French. In addition, a language line was available in all CSHS clinics to assist in communication with clients who do not speak English.

Population Based Services
Staff collaborated with the 2 Medical Home project practices by providing technical assistance and training. One of the Medical Home practices is located in an inner city area and serves a predominately African-American population. These practices had full time care coordinators who worked with families of CYSHCN and assisted them in coordination of services and linkages to other agencies and providers. Staff in CSHS clinics provided coordination of services with all medical home practices by sending copies of clinic notes to the child's identified primary health care provider and coordinating care among all providers for the child. CSHS began the process of implementing a Teen Transition Clinic in the New Orleans and Baton Rouge areas with a pediatric physical medicine and rehabilitation physician.

Infrastructure Building
CSHS administrative staff worked with 2 regions to refine the pilot care coordination program,

which included development of a web-based database. Statewide CSHS staff were given an overview of the care coordination pilot in a training in New Orleans in September. Over 100 staff attended this training. Administrative staff began discussions with the Families Helping Families (FHF) regarding collaboration with the new Family to Family Health Information Centers (F2F HICs) to coordinate some of the services of the CSHS care coordination program. New nursing and nutrition staff in CSHS were given a 4 day skills training on working with CSHCN in September. The Statewide CSHS Parent Consultant and Parent Trainer provided several exercises during the training that gave a parent's perspective of having a CYSHCN and how to work with families. In addition, one staff from each of the 9 regions attended two 2-day Infant Mental Health Trainings in order to prepare them to better identify risk factors and make appropriate referrals.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provide case management services for children attending CSHS clinics.	X	X		
2. Provide assessment and linkage to needed services for CSHCN.	X	X		
3. Provide intensive care coordination services for children and families identified with high level of service need in 1 region of the state.	X	X		
4. Collaborate with primary care practices to improve case management for CSHCN.		X	X	
5. Provide technical assistance to Medical Home practices on issues related to facilitating care coordination services.			X	
6. Train CSHS staff statewide on intensive care coordination services.				X
7. Collaborate with F2F Health Information Center to coordinate care coordination services.			X	
8. Train new staff on issues related to working with CSHCN.	X		X	
9.				
10.				

b. Current Activities

Direct and Enabling Services

The care coordination pilot in 1 region was discontinued and a revised pilot was begun in May 2008. This new program includes a web-based database. The initial population served will be YSHCN ages 14 and older.

Population Based Services

The Teen Transition Clinic was not implemented, as the physician relocated out of state. Teen transition services have been incorporated into the care coordination program. The CSHS website was updated and includes some links in Spanish. CSHS revised its brochure and added a new brochure for physicians. Both of the brochures have been placed on the CSHS website and in PCP offices and have been given out at Health Fairs.

Infrastructure Building Services

A 4 day training was provided to staff in the pilot care coordination program in May -- June 2008. Administrative staff will provide on-site technical assistance during the 3 month pilot period. CSHS collaborated with the F2F HIC on the revised Care Coordination pilot and on ways to coordinate services between the 2 programs. After the 3 month care coordination pilot, an outcome evaluation will be conducted. The results of this evaluation will provide information on the final revision to the program. New nursing, nutrition and social services staff will attend a 4

day didactic and skills training on issues related to working with children with special health care needs and their families in July 2008.

c. Plan for the Coming Year

Objective: To increase to 85% the percent of CSHS patients who have received case management (follow-up visits) from a nurse, social worker, or nutritionist. This target remains the same from the current year. The percentage was changed due to the ongoing difficulty of staff not having adequate time to capture follow-up services in the database. CSHS administrative staff will train all new employees on the significance of capturing accurate follow-up data and provide quarterly reminders to staff.

Direct and Enabling Services

Care coordination will be implemented regionally starting in fall 2008. The goal is to have care coordination services in all regions by the end of 2010. The initial care coordination focus will be YSHCN ages 14 and above and focus on transition services. Care Coordination services will phase-in for other CSHCN at higher risk after implementation of the initial services in all regions. CSHS staff will continue to provide follow-up services to all CYSHCN and their families in CSHS direct services clinics.

Population Based Services

Transition services will be incorporated into the care coordination process for YSHCN attending CSHS clinics. The CSHS website will continue to be updated. CSHS plans to expand the Medical Home project to a 3rd practice in the greater New Orleans area which will serve a predominately Hispanic population. CSHS will have the new brochure translated into Spanish and Vietnamese and also place these translated versions on the website.

Infrastructure Building Services

CSHS will provide training for all staff on the care coordination system at the annual CSHS Conference in October 2008. On-site training will be given to staff in each region as the program is implemented statewide starting in fall 2008. Administrative staff will provide regular technical assistance as each region begins the care coordination program. CSHS will continue to collaborate with Louisiana Rehabilitation Services, Office for Citizens with Developmental Disabilities, Louisiana Department of Education, FHF, and F2F HICs to coordinate services for CSHCN. CSHS will continue to provide a training for all new nursing, nutrition and social services staff on issues related to working the CYSHCN and their families.

State Performance Measure 6: *Percent of infants receiving WIC services through Public Health Units, aged 0-1, screened by the Louisiana Risk Assessment (LRA)-Infant version.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				18	18.5
Annual Indicator			17.4	17.7	8.0
Numerator			6682	6384	3037
Denominator			38509	36114	37810
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	19	19.5	20	20	20

Notes - 2007

Data for this year is for October 2006-2007. In October of 2006, Public Health units began using the LRA as an in-house risk assessment for referral purposes, and no longer submitted it for analysis due to the establishment of SBIRT Assessment.

Notes - 2005
Data for this first year is for May 2005 - April 2006 so that a 12 month period could be analyzed. The Assessments began in May of 2005.

a. Last Year's Accomplishments
There were 3,077 risk assessments collected and a preliminary analysis was done. Regional resource guides were sent to each region for assistance in referring women in need of domestic violence, substance abuse, and other mental health services. In addition, several contract agencies for the Best Start Program have domestic violence programs under their agency umbrella, and referrals to these programs are facilitated. The Mental Health Coordinator has provided training in infant mental health to 50 mental health clinicians, and approximately 80 OPH nurses have received training on behavior problems in very young children through the Child Care Health Consultants program. Another 30 received training on the effects of disaster on very young children and their families.

Louisiana has a number of Hispanic legal and illegal immigrants working in poultry farms in northern Louisiana, so the LRA was translated into Spanish and disseminated statewide. Post Hurricane Katrina, the number of Hispanic women entering the state has increased.

Infrastructure Building Services
Preliminary frequencies have been run on the first 900 LRA assessments. There were 12.5 % of respondents reporting depression during/after pregnancy, 80.8% of women received prenatal care in the 1st trimester, and a 33% reported unintended/unwanted pregnancy. Dissemination of preliminary findings are being sent to all Regions to encourage continued participation in the LRA process and encourage Health Units who have not participated previously to do so. MCH will continue to offer trainings and expand the number of PHUs that participate in the LRA.

A number of activities and the dissemination of literature, in English and Spanish, have taken place to raise provider and client awareness of maternal depression. In addition, Region 4 Nurse Managers received training on the LRA and an article on Maternal Depression was disseminated to health care providers in Louisiana through Partners for Healthy Babies, as well as materials disseminated to over 1000 pregnant women through a Health Baby Fair in the metropolitan region of New Orleans.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Use LRA as a referral tool in OPH PHU.	X			
2. Provide perinatal depression training to OPH Nurses, mental health clinicians, nurses and social workers in Region 1.	X			X
3. Piloted the 4PsPlus, Screening, Brief Intervention, Referral and Treatment, (SBIRT)) to pregnant women at their provider's offices for earlier identification of risk for pregnancy/child outcomes.	X		X	
4. Translate the SBIRT Screening tool in to Spanish.			X	
5. Train local police, emergency mental health responders, and case managers in perinatal depression and Axis 1 disorders during pregnancy.				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities
There were 2,688 Infant Risk Assessments administered. Due to policy changes in WIC, work load capacity following the storm, and a new risk assessment, LRA's are now used for referral purposes in OPH. MCH, Addictive Disorders, Mental Health, ACOG, March of Dimes, Louisiana Public Health Institute, and Louisiana Medicaid, piloted the 4PsPlus, (Chasnoff) to pregnant women at their provider's offices for earlier identification of risk for pregnancy/child outcomes This is the Screening, Brief Intervention, Referral and Treatment Program (SBIRT) (SBIRT)-Healthy Babies Initiative (HBI) in Louisiana. To meet the needs of Hispanic women in Louisiana, the SBIRT is being translated into Spanish, and Spanish speaking providers will administer the tool and provide the brief intervention when needed.

Direct and Enabling Services
Training was provided to 50 clinicians (infant mental health), 80 OPH nurses, 150 clinicians and 50 nurses / social workers in Region 1(perinatal depression).

Infrastructure Building Services
MCH received a HRSA perinatal depression (PD) grant for women impacted by the storm in Region 1. More than 80 women and 30 infants received clinical services. 30 local police, emergency mental health responders, and case managers were trained in PD and Axis 1 disorders during pregnancy.

c. Plan for the Coming Year
SPM 06 will transition in the coming year into a new performance measure due to adoption of the SBIRT-HBI program. The new performance measure will be: Percent of Louisiana resident women giving birth who undergo screening for substance use, depression and domestic violence using the SBIRT-HBI approved methods. The numerator will be the number of women who undergo at least one screen during pregnancy. The denominator will be the number of Louisiana resident women giving birth within the year.

Direct and Enabling Services
The plans being developed to implement SBIRT-HBI screening within WIC clinics throughout the state will be implemented and supported by MCH during the current year. MCH will continue to meet with regional and WIC personnel for technical support of the screening tool use, appropriate brief intervention techniques, and referral sources. Aggregate data on results of screening will be periodically provided back to individual WIC sites. Introduction of a Spanish version of the screen will occur. In the New Orleans region, women who screen positive for perinatal depression will be referred to the Perinatal Depression Program (PDR1) in Region 1. Spanish speaking women will be referred to the Hispanic Apostolate for services. Further, the PDR1 Program will sponsor "Listening Visits" trainings on providing social support for depressed women during perinatal visits to home visiting nurses and other home visiting mental health programs in Regions 1 and the Baton Rouge region. Telemed presentations to home interventionists in other parts of the state are also being planned.

Infrastructure Building Services
MCH with its other SBIRT-HBI partners will continue to urge adoption of the screening tool by all providers within the state, public and private. The tool will be implemented in all 9 public health regions of the state. MCH will continue to work with Medicaid to make use of the screening tool and brief intervention as a reimbursable service under state the Medicaid program. Private providers will continue to receive technical support and screening result data. The work with MCH

EPI to begin data analysis of pregnancy outcomes on women with intervention and treatment from the program will continue.

State Performance Measure 7: *Percent of women who use alcohol during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective				2.8	5
Annual Indicator	2.9	2.9	6.8	6.8	6.8
Numerator	1811	1811	4258	4258	4258
Denominator	62014	62014	62405	62405	62405
Is the Data Provisional or Final?				Final	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	5	5	5	5	5

Notes - 2007
Data is provisional and is based upon the 2004 PRAMS data.

Notes - 2006
Data is based upon the 2004 PRAMS data.

Notes - 2005
Source:

2004 LaPRAMS (Louisiana Pregnancy Risk Assessment Monitoring System) survey of new mothers. For drinking during the last three months of pregnancy.

a. Last Year's Accomplishments
2004 Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data indicates that 6.8% of pregnant women reported drinking during pregnancy. More recent PRAMS data is not available.

Direct and Enabling Services
The Maternal and Child Health (MCH) program in collaboration with Louisiana Section of ACOG, Louisiana Office of Addictive Disorders (OAD), and Office of Mental Health identified a screening tool for alcohol use in pregnancy. This tool, the 4Ps Plus, also screens for substance abuse, tobacco use, depression and domestic violence. State licensure for tool use and data collection from Dr. Ira Chasnoff of the Children's Research Triangle in Chicago was obtained. The tool will be made available to all obstetrical providers within the state for use. The plan is for OAD to fund a regional coordinator in each region of the state, provide treatment resources and coordinate referrals for other treatments. This program is called the Screening, Brief Intervention, Referral and Treatment (SBIRT) Program for Pregnant Women. Three pilot regions (Northshore, Alexandria, Monroe) began services. Baton Rouge will continue its SBIRT program.

The SBIRT program in the 3 pilot regions of the state screened 893 women. The Baton Rouge area screened an additional 2828 women. Brief intervention for alcohol use was performed with 389 women and 90 referrals for more intensive treatment was made.

The voluntary pregnancy testing program for OAD clients continued with 994 receiving tests. The positive pregnancy rate last year was 3.4%. This program allows more rapid diagnosis of pregnancy and referral for prenatal care. For those with negative tests, referrals are made for those desiring family planning services.

The Nurse Family Partnership (NFP) program provided services, including the prevention of substance abuse, in all regions, including 29 parishes. Dr. Ira Chasnoff has presented programs on effects of maternal alcohol use during pregnancy.

MCH collaborated with the March of Dimes (MOD) to begin CenteringPregnancy programs.

Population-Based Services
The Partners for Healthy Babies (PHB) promotions continued with prevention of alcohol use in pregnancy as part of its message. PHB prenatal care fairs were held in New Orleans in October 2006 and in the Northshore Slidell region in March 2007, with more than 900 attendees total.

Infrastructure Building Services
Substance abuse services were identified as a priority need. The Infant Mortality Reduction Initiative (IMRI) focused on factors contributing to high infant mortality and prematurity rates. Alcohol use is a significant contribution to these rates. Regional Feto-Infant Mortality Reviews (FIMRs) are looking at problems and solutions at the local level. The MCH Maternity Medical Director and Nurse Consultant continued visits to OB Medicaid providers and birthing hospitals, providing education and resources. Discussion began with Louisiana Medicaid to make SBIRT screening a pay for performance initiative for providers.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Continue support of statewide perinatal substance abuse plan with the Office of Addictive Disorders and National Training Institute.				X
2. Support Home visitation to low-income mothers and infants.	X	X		
3. Support the Partners for Healthy Babies media and helpline.			X	
4. Support CenteringPregnancy groups.	X	X		X
5. Expand alcohol use in pregnancy screening to all regions of state and in WIC clinics throughout the state.	X	X		
6. Provide voluntary pregnancy testing and referral in Office of Addictive Disorder (OAD) clients.	X			
7. Support Partners for Healthy Babies Prenatal Care Fairs.	X		X	
8. Collaborate with Medicaid on Quality of Care issues and recommendations for funding substance abuse treatment.				X
9. Support regional Feto-Infant Mortality Reviews (FIMRs) to target substance abuse as one of leading risk factors for pre-term labor.				X
10. Collaborate with LPHI to support alcohol prevention messages and activities.				

b. Current Activities
Direct and Enabling Services
SBIRT-Healthy Babies Initiative (HBI) continues in 4 regions. Plans are in place to start services in the Lafayette and New Orleans by summer 2008; with 4 additional regions of the state to initiate services by 2009. Medicaid plans to reimburse for screening and brief intervention services. Planning is currently in place to initiate SBIRT screening in state WIC clinics. WIC clinics in the Baton Rouge area have begun screening. NFP continues to address alcohol use in pregnancy in all areas of the state. MCH continues to support CenteringPregnancy programs.

Population-Based Services
Two Partners for Healthy Babies (PHB) prenatal care fairs were held; MCH collaborated with Native American tribe and Bureau of Minority Affairs. The PHB campaign continues web-based and multimedia approaches.

Infrastructure Building Services
FIMR Community Action Teams (CATs) provide local infrastructure to address alcohol use. MCH staff continues education visits to private OB's and birthing hospitals in all regions. MCH Nurse Consultant conducted Substance Abuse awareness trainings in Monroe SBIRT pilot region via AMCHP grant to ALL Collaborative. A contract has been initiated with the Louisiana Public Health Institute for a manager level individual in their organization, funded by MCH, to address MCH concerns, including alcohol use in pregnancy. Regional FIMR meetings are providing information on the need for standardized message of "no alcohol use in pregnancy".

c. Plan for the Coming Year
Objective: Reduce the percent of women who use alcohol during pregnancy to 6.7%.

Direct and Enabling Services
The HBI program will expand statewide and be utilized in WIC clinics throughout the state. This tool is being provided to all obstetrical providers, and could potentially screen every pregnant woman in the state for alcohol use. Use of the tool in Family Planning clinics is being planned. Each region will have HBI coordinators and treatment resources. Epidemiological evaluation of the HBI program will begin.

Health units providing prenatal care will continue to screen for alcohol and offer brief intervention and referral for cessation services.

The NFP program will continue to address substance abuse during pregnancy, providing education, counseling and referrals for women in need of these services in all regions of the state.

Population-Based Services
PHB will continue the promotion of healthy pregnancy campaigns, with prevention of alcohol use in pregnancy as a part of that message. Additional prenatal care fairs are being scheduled through the Partners for Healthy Babies campaign.

Infrastructure Building Services
The HBI will continue to build local support for screening, intervention, treatment, and prevention of alcohol use in pregnancy. All regions of the state will have HBI activities.

The IMRI is continuing to work with Regional MCH FIMRs. These groups will promote local strategic planning to provide infrastructure to address alcohol use and its impact on pregnancy. The MCH Medical Director and Nurse Consultant will continue to visit and educate private OB providers with large Medicaid practices and birthing hospitals, reaching all 9 regions.

MCH will continue to meet with Medicaid to promote efforts to enhance quality of care issues. Discussions will continue with Medicaid to reimburse and possibly mandate implementation of screening / intervention.

A manager level individual will be in place with LPHI to address MCH concerns, including alcohol use in pregnancy.

State Performance Measure 8: *Rate of infant deaths due to Sudden Infant Death Syndrome.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	0.9	0.8	1.1	1.1	1
Annual Indicator	1.1	0.8	1.3	0.9	0.9
Numerator	70	51	77	54	54
Denominator	64689	64956	60531	62416	62416
Is the Data Provisional or Final?				Provisional	Provisional
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	1	1	1	1	1

Notes - 2007
Data is provisonal and based upon the 2006 data.

Notes - 2006
Data is provisional. Vital Statistics Data is used this year. SIDS Program Data is not available at this time.

Notes - 2005
Vital Statistics Data is used this year. SIDS Program Data is not available at this time. Data is final.

a. Last Year's Accomplishments
The Sudden Infant Death Syndrome (SIDS) death rate per 1,000 live births was 1.3 in 2005. The SIDS rate for African Americans in 2005 was 1.8. The SIDS rate for Caucasians in 2005 was 1.0. Overall the racial disparity for 2005 was 1.8 PRAMS data indicate that back sleeping has increased from 32% in 1997 to 56% in 2004.

Direct and Enabling Services
Children's Bureau continued to be available to provide counseling for families of SIDS/OID (Other Unexpected Infant Death) victims. Children's Bureau served 7 families with counseling and support for SIDS/OID and continued its network of parent peer contacts and community health educators to provide additional counseling and resources for SIDS/OID families. The Office of Public Health (OPH) provided counseling to 16 families in the rest of the state. A pilot research plan continued to be implemented to provide safe sleep environment education in WIC clinics.

Population-Based Services
A social marketing public information campaign about safe sleep environment was implemented within high-risk areas of the state, with focus on the dissemination of the new safe sleeping guidelines by American Academy of Pediatrics (AAP). Educational materials on new AAP guidelines on safe sleeping were distributed to the general public. New educational print materials on the new safe sleeping guidelines were developed in English and Spanish. Approximately 20,000 print materials were distributed. SIDS information continues to be distributed statewide to birthing hospitals, healthcare and daycare providers. The SIDS Program continued collaboration with community-based agencies to provide approximately 75 educational sessions.

Infrastructure Building Services
The MCH Program contracts with Tulane University School of Medicine, Pediatric Pulmonary Section, for the position of SIDS Medical Director. This has continued improved capacity to identify, counsel and follow-up with SIDS families, and improved monitoring of the overall program. There were 73 reimbursements to coroners for complete autopsy reports and 43 reimbursements for complete death scene investigations. The Louisiana Child Death Review Panel (CDRP) reviewed all unexpected deaths in children under age 15, including all SIDS deaths. There were a total of 86 sudden unexplained infant deaths that were reviewed by the

Louisiana Child Death Review Panel. After thorough review, 24 infant deaths were reclassified by the SIDS Medical Director.

A SIDS Program Coordinator works to establish community-based education on SIDS risk reduction in high risk areas. MCH provided SIDS education programs to daycare providers, public health nurses, coroners, law enforcement, social workers and the general public.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Review autopsy and death scene investigations.				X
2. Present SIDS related education programs to health professionals, law enforcement and the public.			X	X
3. Distribute educational materials to hospitals, health providers and daycare centers.				X
4. Collaborate with community-based organizations and the faith community to disseminate SIDS risk reduction message.			X	
5. Disseminate new American Academy of Pediatrics Safe Sleep Guidelines to healthcare professionals.				X
6. Develop and implement pilot research plan to provide safe sleep environment education through WIC clinics.			X	X
7. Administer social marketing campaign about safe sleep environment promotion within high-risk areas.			X	
8. Provide grief counseling for families of SIDS/OID victims through agency collaboration.		X	X	
9. Promote regulatory guidelines for safe sleep environment in day care and family day home centers.		X		
10.				

b. Current Activities

Direct and Enabling

The SIDS Program continues to coordinate with Children's Bureau to provide grief counseling for families of SIDS/OID victims in the New Orleans area.

Population-Based Services

The social marketing public information campaign about safe sleep environment continues within high-risk target population areas through media, community and medical profession outreach. Current campaign efforts continue to target racial disparities through media placement in low income populations. Education materials continue to be distributed.

Infrastructure Building Services

The SIDS Program continues collaboration with community-based agencies in dissemination of risk reduction message. Provider information on new AAP safe sleep guidelines continues to be distributed. The SIDS Medical Director reviews autopsy and death scene investigations. The CDRP continues reviewing all unexpected deaths in children under the age of 15, including all SIDS deaths. The Child Death Review Panel is collaborating with the SIDS Program to conduct trainings for coroners, death scene investigators, first responders, and stakeholders on conducting death investigations in a culturally competent manner consistent with standard protocol, have knowledge about causes of unexpected infant and child death, and demonstrate sensitivity in their role in addressing family needs.

c. Plan for the Coming Year
Objective: To reduce to 0.8 per 1,000 live births the number of infant deaths due to Sudden Infant Death Syndrome.

Direct and Enabling Services
Children's Bureau plans to continue to provide counseling and resources for families who are victims of SIDS/OID (Other Infant Deaths) as needed in the Greater New Orleans area. The OPH will continue to provide bereavement support to SIDS families in the remainder of the state. The SIDS Program will analyze the results form the pilot SIDS WIC study clinics and disseminate findings to the public. Results from the Louisiana SIDS Safe Sleep Program qualitative research study, to determine awareness of both consumers and providers about safe sleep practices for infants and to identify potential barriers related to these practices, will be used to develop culturally competent educational materials.

Population-Based Services
The social marketing public information campaign about safe sleep environment promotion will continue to be implemented within high-risk target population areas of the state through media, community outreach and medical profession outreach. Evaluation of media messages and materials will continue to be performed through formative research. Market research will be used to develop new campaign strategies to effectively target hard to reach populations. The SIDS Program will continue to collaborate with MCH Child Safety Coordinators in regional risk reduction activities such as educational and crib giveaway programs.

Infrastructure Building Services
The SIDS Program will continue interagency collaboration with existing community-based agencies and organizations in promotion of safe sleep environment messages. The SIDS Program will continue to provide technical assistance for development of policy and/or regulatory standards related to safe sleep environment in licensed childcare. The SIDS Program plans to continue provision of training for licensed childcare and family day home providers related to safe sleep environment. Training will be provided to health care professionals and providers including physicians, nurses and OPH Program staff such as Early Steps, NFP, Best Start, social workers, PHU nurses and hospitals.

Autopsy and death scene investigations will continue to be reviewed by the SIDS Medical Director. Infant Death Scene Investigation trainings will continue at the regional level to ensure that coroners, death scene investigators, first responders, and stakeholders possess the necessary skills to respond in a supportive, culturally competent manner to families who have experienced a sudden unexpected death and ensure protocol is performed to standard.

Child Death Review Panel will continue reviewing SIDS deaths as well. Special reports on infant mortality will continue to be provided to the State Commission on Perinatal Care and Infant Mortality and other interested groups.

State Performance Measure 9: *Percent of state fetal and infant deaths reviewed by a Feto-Infant Mortality Review (FIMR).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				7.5	15
Annual Indicator		7.7	11.7		
Numerator		66	78	132	
Denominator		857	666		
Is the Data Provisional or Final?				Provisional	Provisional

	2008	2009	2010	2011	2012
Annual Performance Objective	20	30	50	50	50

Notes - 2007
2006 data on number of fetal and infant deaths is not available from Louisiana Vital Statistics at the time.

Notes - 2006
2006 data on number of fetal and infant deaths is not available from Louisiana Vital Statistics at the time.

a. Last Year's Accomplishments
Population-Based Services
Recommendations from the regional FIMR CATs resulted in population-based interventions. Partners for Healthy Babies activities have been coordinated with regional FIMRs.

Infrastructure Building Services
In 2001, Louisiana MCH program began the promotion and development of a state-wide FIMR process by supporting regional communities in the development of a standard fetal and infant death review process. This review is an important part of understanding the factors contributing to the deaths in our state, informing the community of the issues, and mobilizing the community to action to prevent these deaths. The reviews began in regions with the strongest infrastructure, systematically expanding to encompass all nine regions in Louisiana. The plan was to focus on the largest parish in each of the nine regions of the state, with each regional team expanding to address additional parishes in the region over time. MCH funds a FIMR coordinator in each of the active regions. The coordinator abstracts and summarizes death charts, conducts a home visit to the mother and presents the cases to the Case Review Team (CRT), and works to organize and maintain the local Community Action Team (CAT).

Regional FIMRs have evolved into active MCH Coalitions, with CRT and CAT members advocating for the needs of mothers and infants, including developing resource lists, involvement in media campaigns for SIDS, SIUDS, substance use, depression, domestic violence, legislative contacts regarding health policy and reform, minority health events and outreach efforts, and involvement of more local government and business leaders. FIMRs conducted 23 CRT meetings and 20 CAT meetings in the six active regions. The FIMR program has been endorsed by the state Perinatal Commission and declared it free from discoverability in legal cases. This information was provided to all partners in the FIMR program and birthing hospitals. Work with state Vital Records was performed to establish a death notification process to the FIMR coordinators.

Six of nine DHH regions had a coordinator and were actively involved in the FIMR review process. CRTs in the active regions reviewed 172 deaths, to help identify important issues surrounding these deaths.

Collaborations with regional organizations supports the salary in one region through the Healthy Start City of New Orleans of one of the regional FIMR coordinators. Family Road of Greater Baton Rouge and Family Tree, each Healthy Start sites, supported the regional FIMR through supplies and administrative support and contracts Collaboration with regional Office of Public Health (OPH) Medical Directors and Administrators and regional epidemiologists supported the FIMR coordinators. Obstetricians and pediatricians from regional hospitals participated on Case Review Team and functioned as FIMR Medical Directors in six regions. Regional community organizations participated on each FIMR Community Action Team meeting. Over 500 community and provider groups statewide participate in the FIMR program.

Plans were being made for an online, electronic FIMR reporting system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Support and assist regional FIMR Case Review Teams (CRT).				X
2. Support FIMR CRT expansion into additional hospitals.				X
3. Help facilitate identification of deaths for FIMR review through vital records system.				
4. Provide Technical Assistance to FIMR coordinators.				X
5. Present state and regional epidemiologic data to FIMRs				X
6. Support FIMR forums and Community Action Teams.				X
7. Assist regional FIMR community teams with intervention ideas and/or implementation of activities to improve outcomes.			X	X
8.				
9.				
10.				

b. Current Activities

Population-Based Services

Regional efforts to address community specific issues continue. FIMRs work with the Partners for Healthy Babies program. MCH, in collaboration with regional FIMRS, assure that regional disaster plans are in place.

Infrastructure Building Services

The Louisiana FIMR network is rebuilding and maturing with MCH support through funding, technical assistance, education and coordination. Coordinators have been hired in the New Orleans and Baton Rouge regions. Region 3 will have a coordinator this year, completing coverage in all regions. The reluctance of some hospitals to work with FIMR has been addressed by the State Perinatal Commission via licensure ruling requiring cooperation. The Commission is working with Coroners to urge involvement with FIMR. Work continues with state Vital Records on the timely provision of death certificate information to FIMR Coordinators. A statewide 6th Annual FIMR Annual Meeting was held in Baton Rouge in March 2008, focusing on preconception health with Dr. Michael Lu as primary speaker. Tulane University's MCH Leadership Training continues for FIMR staff.

In 2007, there were 164 cases reviewed by Louisiana FIMR. We project these cases will represent 7-7.5% of deaths in 2007 as the final number of fetal and infant deaths for 2007 is not available. Regional FIMRs are conducting monthly CRT meetings and quarterly CAT meetings. An online, electronic FIMR reporting system was brought into use by active regions.

c. Plan for the Coming Year

Objective: Increase the percentage of fetal and infant deaths reviewed by a FIMR to 20%

Population-Based Services

Recommendations from the regional FIMR CATs and forums continue to result in population-based interventions including SIDS crib giveaways with Walmart, faith based initiative in Central Louisiana with African American church pastors, educational presentations to local university nursing programs, expanding resource directories to include services for substance use, domestic violence, depression. Efforts are underway to develop Breastfeeding resources regionally. The Partners for Healthy Babies program works with FIMR coordinators in educational efforts.

Infrastructure Building Services
All nine regions of the state will be active in FIMR reviews. As previously stated, the reviews were initially restricted to deaths in the largest parish of each region. We anticipate that as staffing is available, we will expand reviews to other parishes in each region. This will help to expand the number of case abstractions and reviews. While work with Vital Records has allowed access to death certificates, the timeliness of this process could be improved. Work in that arena will occur.

Regional FIMRs will continue to review cases and support community interventions. Opportunity for community action will be carried out through FIMR community groups and regional forums. The FIMR review teams regularly provide recommendations to the established Community Action Teams and Regional forums. These Community Teams continue to support measures to address circumstances surrounding fetal and infant deaths at the community level throughout Louisiana. The Screening, Brief Intervention, Referral and Treatment for substance use, domestic violence and depression (SBIRT)-Healthy Babies Initiative (HBI) will expand to all regions of the state, and include WIC clinics. FIMR groups are working closely with regional SBIRT-HBI coordinators to identify needs, community resources, and provide education through CRT/CAT meetings.

In addition to case reviews, regional FIMR groups continue to update emergency plans for MCH populations, especially pregnant women, new mothers, and infants.

FIMR will continue to work with the State Perinatal Commission to advance support for this important review process. MCH anticipates further strengthening collaborations with March of Dimes and ACOG as well as other community-based organizations through the Regional FIMR teams. Targeted educational activities to regional providers and stakeholders will help encourage regional action to address prematurity and VLBW births. Tulane University's MCH Leadership Training grant will continue to provide teleconference education for FIMR coordinators on Leadership, Social Marketing, Cultural Diversity, and working with legislators and the press.

Continued use of the online, electronic reporting system, Basinet, will occur, with data aggregation of cases reviewed.

State Performance Measure 10: *Percent of licensed day care centers with a health consultant contact.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2003**	**2004**	**2005**	**2006**	**2007**
Annual Performance Objective	37	55	35	39	40
Annual Indicator	52.2	31.0	38.4	32.4	85.4
Numerator	1039	673	833	565	1490
Denominator	1989	2170	2170	1744	1744
Is the Data Provisional or Final?				Final	Final
	2008	**2009**	**2010**	**2011**	**2012**
Annual Performance Objective	95	98	99	100	100

Notes - 2007
FY07 data is based on a report provided by the Louisiana DHH Center for Environmental Services. The report documents the number of child care facilities that met the DHH Center for Environmental Services requirements for licensure during the Block Grant FY. Child care staff is required by DHH to have three hours of health and safety training provided by Child Care Health Consultants (CCHC). Parish Sanitarians inspect centers for proof of the three hours of health and safety training provided by a CCHC and for other requirements to ensure a safe environment. Louisiana DHH Center for Environmental Services compiles a database of the centers that pass this inspection and are recommended for licensure.

Notes - 2006
FY 2006 data is based on the Child Care Health Consultant monthly report system.

Notes - 2005
FY 2005 data is based on the Child Care Health Consultant monthly report system.

a. Last Year's Accomplishments
As of September 2007, there were approximately 1744 licensed child care facilities in the state. In FY 2007, 1490 (85%) of these child care centers had contact with a Child Care Health Consultant (CCHC).This information was obtained from the Department of Health and Hospitals (DHH) Center for Environmental Health Services. In previous block grants this information was obtained from self-report by CCHC Activity Report Logs. These logs have been stream-lined to encourage more accurate reporting.

Infrastructure Building Services

The Annual CCHC Certification Conference was held in September 2007. The conference included topics based on the curriculum recommended by the National Training Institute for CCHC, Topics included medication administration, new recommendations from the American Academy of Pediatrics on Safe Sleep Practices for infants, an overview of the state's child care and resource agencies, CCHC role in helping child care facilities achieve high scores on the early childhood environmental rating scales, nutrition in the child care setting, and maternal depression, Twenty--nine new individuals and 22 previously certified CCHC were certified. There are a total of 150 certified CCHC in the state. There were 1744 licensed child care centers in Louisiana Child Care Health Consulants continue to conduct satisfaction surveys of their trainings at least twice during the year. These satisfaction surveys have continued to be positive. MCH Safety Coordinators that are certified as CCHC work in each of the nine (9) regions in the state. The MCH Safety Coordinators provided 67 trainings to 1873 child care providers. The top five topics that were most frequently trained on were injury prevention/safety, food safety/sanitation, nutrition, infectious diseases, and immunizations.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate training opportunities and technical assistance in health and safety in child care.				X
2. Plan, initiate and coordinate certification training for Child Care Health Consultants.				X
3. Provide educational materials and training to child care providers on services for CSHCN and related to health and safety.			X	X
4. Serve as a child care health resource to child care providers and others.			X	X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Infrastructure Building Services
During the 2007 Annual Child Care Health Consultant Conference, CCHC were educated on Louisiana's child-care Quality Rating System (QRS), Quality Start. In addition, updates on the new American Academy of Pediatrics (AAP) guidelines for a safe sleep environment were provided. A video conference entitled "Recognizing Child Abuse in the Child Care Setting" was presented to CCHC in March 2008. Signs and symptoms of possible child abuse and mandates for reporting were discussed. Copies of Caring for Our Children: National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs, 2nd Edition are distributed on an on-going basis. Technical assistance is being provided through the Child Care Health Consultant Program Director to Child Care Providers, CCHC, the DSS Child Care Licensing Regulatory Section, and parents.

c. Plan for the Coming Year
Objective: Increase the percent of licensed day care centers with a health consultant contact to 95%.

The Maternal Child Health Program provides continuing education to the CCHC during its annual certification conference and quarterly statewide video conferences. The next conference is planned for April - May 2008. Along with the standardized basic information for all new CCHC, the next conference will include: guidelines for developing a training model to help child care providers develop an emergency preparedness plan, new recommendations from the American Academy of Pediatrics on Safe Sleep Practices for infants, an overview of Louisiana's new Quality Rating System for Child Care Centers, food allergies, Louisiana's social emotional newsletter for parents, and Adult Learning Theories and Practices. These categories were chosen based on: previous Need's Assessment, comments on evaluation forms, verbal comments received from CCHC, and the curriculum developed by the National Training Institute for Child Care Health Consultants. A presentation on Cultural Competency in the Child Care and Early Education Setting and available community resources will be provided to the CCHC during a video conference this year and will be incorporated into the annual conference curriculum. In addition, CCHC will be given a fact sheet and a list of websites on cultural competency to distribute to child care and early education facilities.

The Child Care Health Consultant Program has been approved to obtain technical assistance from the Healthy Child Care Network: National Resource Center. Technical assistance will be provided to help further develop the CCHC Programs' Evaluation Plan.

The CCHC Program plans to have an integral part in helping child-care facilities achieve "stars" on Louisiana's Quality Start Program. This involvement will include providing education and technical assistance to child care providers in order to improve their scores on the environmental rating scales in the areas that pertain to health and safety. In addition, the CCHC Program plans to continue to focus its efforts on facilitating training for CCHC by collaborating with agencies/organizations involved with children's issues such as the DSS Child Care Licensing Regulatory Section, DHH Center for Environmental Health Services, Epidemiology Departments, the Immunization Program, and Child Care Resource & Referral Agencies.

The CCHC Program is integrated into the following components of the Louisiana BrightStart (ECCS) Strategic Plans: a) Training in social-emotional development of young children, b) Training on benefits of a medical home, and c) Provision of three hours of health and safety training covered by ECCS funding. Access to the CCHC database will be available via the Partners for Health Babies and Agenda for Children Websites.

E. Health Status Indicators

#01A. The percent of live births weighing less than 2,500 grams

/2009/ Final 2005 data revealed percent of live births less than 2,500 grams to be 11.5%. Preliminary 2006 data is also 11.5%. //2009//

/2008/ In 2005, the percent of live births weighting less than 2,500 grams was 11.5 % of all births. This was an increase from 11.0% in 2004.//2008//

Low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing low birth weight infants, by regions and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions.

Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs. ***/2009/ The challenges that have been present since the 2005 hurricanes may have contributed to the increase in low birth weight singleton infants. Access to care (both contraceptive and prenatal care) was disrupted and remains difficult for some groups, and in some areas. The stress associated with loss of home, loss of employment, loss of medical care, and social issues may contribute to low birth weight. Louisiana does now have a family planning waiver, Take Charge, to assist in access to these services for Medicaid eligible women. Work is in progress to link enhanced preconception services, especially folic acid use, to the family planning program. The SBIRT program is providing screening/intervention services for substance abuse and mental disorders, in 4 regions now, expanding to 6 by mid-2008, and will be in all regions by 2009. //2009//***

New data linkages will be developed with Louisiana Hospital Inpatient Discharge Data (LaHIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are established to access to the Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data.

The state can enhance data capacity through the improvement of existing data linkages and the establishment of new data linkages and surveillance systems. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses and evaluation by the MCH and CSHCN Programs, which identify priority needs for programs and interventions.

#01B. The percent of live singleton births weighing less than 2,500 grams

/2008/ In 2005, the percent of live singleton births weighting less than 2,500 grams was 9.5% of all births. This was an increase from the 9.1% rate noted in 2004.//2008// ***/2009/ In the final 2005 data, the percent of live singleton births weighing less than 2,500 grams was 9.5%. The preliminary 2006 data remains at 9.5%. This is an increase over the 2004 rate of 9.1%. //2009//***

Low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing low birth weight infants, by regions and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions.

Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs.

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#02A. The percent of live births weighing less than 1,500 grams

/2008/ In 2005, the percent of live births weighing less than 1,500 grams was 2.3% of all births. This was an increase from the 2004 rate of 2.1%.//2008//

Very low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing very low birth weight infants, by regions and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions.
Specific interventions include the Infant Mortality Reduction Initiative, smoking cessation program, dental services program, substance abuse and depression screening programs.

New data linkages will be developed with Louisiana Hospital Inpatient Discharge Data (LaHIDD) and with the Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS). Efforts are established to access to the Louisiana Birth Defects Survey conducted by CSHCN and Caring Community Youth Survey conducted by the Office for Addictive Disorders, and increase data analysis and dissemination of information from PRAMS and its linked data.

The state can enhance data capacity through the improvement of existing data linkages and the establishment of new data linkages and surveillance systems. Current linkages between the birth files, infant death files, Medicaid eligibility files, women, infant, and child program (WIC) eligibility files, and newborn screening data will continue to allow in depth analyses and evaluation by the MCH and CSHCN Programs, which identify priority needs for programs and interventions.

#02B. The percent of live singleton births weighing less than 1,500 grams.

/2008/ In 2005, the percent of live births weighing less than 1,500 grams was 2.3% of all births. This was an increase from the 2004 rate of 2.1%.//2008//

Very low birth weight can provide valuable information as a general indicator of the state's maternal health status and prenatal care provision. While a surrogate marker for prematurity, it can also identify infants who have intrauterine growth restriction. By analyzing very low birth weight infants, by regions and specific population groups such as payer type, it can help direct resources to those areas in most need. By following this figure over time, one can obtain a general measure of risks and results of interventions.
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#03A. The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

/2009/ Final 2005 Louisiana data for death rate for unintentional injuries of children under age 15 years is 15.9 per 100,000, which is lower than the 2004 death rate. Preliminary 2006 data a further decrease of the death rate to 11.9 per 100,000. //2009//
/2008/ In Louisiana, unintentional injuries are a leading cause of morbidity and mortality from ages 1 through 14 years. Preliminary data indicate that the 2005 death rate for unintentional injury among children aged 14 years and younger is 12.2 per 100,000, which is less than the death rates in 2004 (18.2 per 100,000) and in 2003 (12.6 deaths per 100,000).//2008//

Most unintentional injury fatalities can be prevented. Therefore, unintentional injury fatality data surveillance enables policy makers to identify behavioral risk factors and the "at risk "groups; prioritize, plan, and implement prevention interventions; and trigger community and/or legislative action which targets behaviors that endanger children. Contributing to the rise in the unintentional injury death rate are the increasing death rates, from 2003 to 2004, of motor vehicle crashes (from 4.7 to 7.0 per 100,000); exposure to smoke and fire (from 1.9 to 2.8 per 100,000); and accidental drowning and submersion (from 2.0 to 2.2 per 100,000). /2008/ In Louisiana, motor vehicle crashes are still the leading causes of unintentional injury-related deaths among children under age 15 years.//2008//

/2008/As an evaluative measure, MCH can assess effectiveness and appropriateness of intervention efforts of and resource allocation over time for the MCH Regional Injury Prevention Coordinators as well as other such MCH supported programs and activities as: SIDS Risk Reduction Program, for safe sleeping environments; Child Care Health Consultant Initiative, for health and safety in child care environments; School Base Health Centers, for health and safety in schools; Safe Kids Louisiana, Inc., for safe homes, communities, recreation/play, and child passenger safety; Public Health Units, for health and safety outreach and education efforts to families; and State and Local Child Death Review Panels, for case reviews and prevention intervention.//2008//

#03B. The death rate per 100,000 from unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.

/2009/ According to final 2005 Louisiana data, the death rate of unintentional injuries from motor vehicle crashes for ages under 15 years is 5.1 per 100,000, which is lower than the 2004 death rate. Provisional 2006 data suggests a further decrease of the death rate to 4.2 per 100,000. //2009//
/2008/ Provisional 2005 Louisiana data indicate that the number of unintentional injury deaths from motor vehicle crashes (mvc's) among children aged 14 years and younger increased in 2005 is 4.4 deaths per 100,000, which is lower than the rates for 2004 (7.0 deaths per 100,000)

and 2003 (4.6 deaths per 100,000).//2008//

Motor vehicle crashes (MVCs) are one of the most common causes of unintentional injuries in this age group. The most effective way to reduce deaths from MVCs is to wear seat belts and to properly restrain child passengers. Therefore, data surveillance is needed to enable policy makers to identify behavioral risk factors; prioritize, plan, and implement prevention interventions; and trigger community and/or legislative action which targets behaviors that endanger children.

/2008/As an evaluative measure, MCH can assess effectiveness and appropriateness of intervention efforts of and resource allocation over time for the MCH Regional Injury Prevention Coordinators as well as other such MCH supported programs and activities as School Base Health Centers, for health and safety in schools; Safe Kids Louisiana, Inc., for safe homes, communities, and child passenger safety; Public Health Units, for health and safety outreach and education efforts to families; and State and Local Child Death Review Panels, for case reviews and prevention intervention.//2008//

#03C. The death rate per 100,000 from unintentional injuries for youth aged 15 through 24 years due to motor vehicle crashes.

/2009/ According to final 2005 Louisiana data, the death rate of unintentional injuries from motor vehicle crashes for ages 15 through 24 years is 35.0 per 100,000, which is lower than the rates for 2004 (36.2 per 100,000) and 2003 (35.2 deaths per 100,000). Provisional 2006 data suggests a further decrease of the death rate to 31.3 per 100,000 //2009//.
/2008/ Provisional 2005 Louisiana data indicate that the number of unintentional injury deaths from motor vehicle crashes (mvc's) among youth aged 15 through 24 years in 2005 is 28.5 deaths per 100,000, which is lower than the rates for 2004 (36.2 deaths per 100,000) and 2003 (35.2 deaths per 100,000).//2008//

Motor vehicle crashes (MVCs) is one of the most common causes of unintentional injuries in this age group. The most effective way to reduce deaths from MVCs is to wear seat belts. Therefore, data surveillance is needed to enable policy makers to identify other behavioral risk factors; prioritize, plan, and implement prevention interventions; and trigger community and/or legislative action which targets behaviors that endanger children.

/2008/ As an evaluative measure, MCH can assess effectiveness and appropriateness of intervention efforts of and resource allocation over time for the MCH Regional Injury Prevention Coordinators as well as other such MCH supported programs and activities as School Base Health Centers, for health and safety in schools; Safe Kids Louisiana, Inc., for safe homes, communities, and child passenger safety; Public Health Units, for health and safety outreach and education efforts to families; and State and Local Child Death Review Panels, for case reviews and prevention intervention.//2008//

#04A. The rate per 100,000 of all non-fatal injuries among children aged 14 years and younger.
/2009/
Louisiana 2006 data is provisional. According to the final 2005 data, the nonfatal injury rate of children under 15 years of age is 249.9 per 100,000, which is higher than the rates for years 2002-2004. //2009//
/2008/Louisiana 2005 and 2006 data are provisional. In 2004, the rate of nonfatal injuries among children aged 14 years and younger was 219.1 per 100,000, which is higher than the rates of 2001 (315.9 per 100,000), 2002 (171.1 per 100,000), and 2003 (164.6 per 100,000).//2008// In 2003, the rate per 100,000 of all non-fatal injuries among children aged 14 years and younger was 164.6.

Louisiana 2004 and 2005 data are provisional. However, the rate of nonfatal injuries among

children aged 14 years and younger has decreased from 2001, at 315.9 per 100,000, to 164.6 per 100,000 in 2003. In 2000, the rate was 267.4 per 100,000.

Most injuries can be prevented. Therefore, non-fatal Injury data surveillance is needed to enable policy makers to identify causes of non-fatal injuries; identify behavioral risk factors and the "at risk " groups; prioritize, plan, and implement prevention interventions; and trigger community and/or legislative action which targets behaviors that endanger children.

/2008/This HSI can also function as an evaluative measure whereby MCH can assess effectiveness and appropriateness of intervention efforts of and resource allocation over time for the MCH Regional Injury Prevention Coordinators as well as other such MCH supported programs and activities as: SIDS Risk Reduction Program for safe sleeping environments; Child Care Health Consultant Initiative for health and safety in child care environments; School Base Health Centers, for health and safety in schools; Safe Kids Louisiana, Inc. for safe homes, communities, recreation/play, and child passenger safety; the Public Health Units for health and safety outreach and education efforts to families; and the State and Local Child Death Review Panels for case reviews and prevention intervention.//2008//

#04B. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger.

/2009/ Final 2005 Louisiana data for the rate of nonfatal injuries due to motor vehicle crashes among children under age 15 years is 42.5 per 100,000, which is unchanged from 2004. The 2006 data is provisional. //2009//
/2009/ In 2007, the rate per 1000 women aged 20 through 44 years with a reported case of Chlamydia was 11.1, up from 10.6 in 2006. Public health efforts to lower this rate include the routine screening in Family Planning and STD clinics. During 2007, the Family Planning Program screened 26,390 20-44 year olds and the STD Program screened 11,792 20-44 year old women. //2009//
/2008/ Louisiana 2005 and 2006 data are provisional. However, the 2004 rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger is 42.5 per 100,000, which is less than the rates for 2001 (47.2 per 100,000), 2002 (48.2 per 100,000) and 2003 (49.5 per 100,000).//2008// In 2003, the rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger was 49.5.

Louisiana 2004 and 2005 data is provisional. However, the rate of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger has increased from 2000, at 36.6 per 100,000, to 49.5 per 100,000 in 2003.

Motor vehicle crashes (MVC) are one of the most common causes of non-fatal injuries in this age group. The most effective way to reduce injuries from MVCs is to wear seat belts and to properly restrain child passengers. Therefore, non-fatal injury data surveillance is needed to enable policy makers to identify behavioral risk factors and the "at risk " groups; prioritize, plan, and implement prevention interventions; and trigger community and/or legislative action which targets behaviors that endanger children.

/2008/This HSI can also function as an evaluative measure whereby MCH can assess effectiveness and appropriateness of intervention efforts of and resource allocation over time for the MCH Regional Injury Prevention Coordinators, Louisiana Safe Kids, Inc, School-based Health Centers, Public Health Units, and the State and Local Child Death Review Panels.//2008//

#04C. The rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.

/2009/ Louisiana 2006 data is provisional. Final 2005 Louisiana data for the rate of nonfatal

injuries due to motor vehicle crashes among the age group of 15 through 24 years is 135.1 per 100,000, which is lower than the rates of years 2001-2004. //2009//
/2008/Louisiana 2005 and 2006 data are provisional. However, the rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years has continued to decrease from rates of 2001 (153.4 per 100,000) and 2002 (148.8 per 100,000) to 139.2 per 100,000 in 2004. There were only 4 more nonfatal injuries in 2004 compared to 2003.//2008// In 2003, the rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years was 138.5.

Louisiana 2004 and 2005 data is provisional. However, the rate of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years has decreased from 2001, at 153.4 per 100,000 to 138.5 per 100,000 in 2003. There was an 18.8% rate increase in 2000 to 150.5 per 100,000 (from 126.7 in 1999) and a 1.9% rate increase in 2001.

Motor vehicle crashes (MVC) are one of the most common causes of non-fatal injuries in this age group. The most effective way to reduce injuries from MVCs is to wear seat belts. Therefore, non-fatal injury data surveillance is needed to enable policy makers to identify behavioral risk factors and the "at risk" groups; prioritize, plan, and implement prevention interventions; and trigger community and/or legislative action which targets behaviors that endanger children.

This HSI can also function as an evaluative measure. By comparing the state's non-fatal injury rates from MVC to past rates and to other states' rates, MCH can assess effectiveness and appropriateness of intervention efforts and resource allocation over time of the MCH Regional Injury Prevention Coordinators, the state's Injury Prevention Program, Louisiana SAFE KIDS, Inc, and public health unit outreach and education efforts.

#05A. The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.

/2009/ In 2007, the rate per 1000 women aged 15 through 19 years with a reported case of Chlamydia was 33.8, up from a rate of 31.4 in 2006. This rate is lower than the 2004 (pre-Hurricane Katrina) rate of 40.3. Although this decrease initially appears to be a positive result, there is concern that fewer adolescents are being screened than before Hurricane Katrina. //2009//

/2008/ In 2006, the rate per 1000 women aged 15 through 19 years with a reported case of Chlamydia was 31.4, up from a rate of 29.5 in 2005. Public health efforts to lower this rate include the continued implementation of STI screening best practices for school-based health centers (SBHCs) throughout the state and incorporation of STI screening as part of the continuous quality improvement initiative of the Adolescent School Health Program. All new SBHCs are now required to provide STI screening onsite. ***/2009/ Beginning in SFY 2008-09, all SBHCs serving 9th graders and higher are required to provide onsite STI testing and treatment. //2009//***

The Office of Public Health Family Planning and STD programs routinely screen for Chlamydia. During 2006, the Family Planning Program screened 10,170 15-19 year olds, and the STD Program screened 7,635 15-19 year olds.//2008//

For 2005 provisional data, the rate per 1,000 women aged 15 through 19 years with a reported case of Chlamydia was 29.6, down from a rate of 40.3 in 2004. Public health efforts to lower this rate include the development of sexually transmitted infections (STI) screening best practices for school-based health centers throughout the state and incorporation of STI screening as part of the continuous quality improvement initiative of the Adolescent School Health Program. In August of 2005, SBHC medical providers were trained in screening, diagnosis and treatment of STIs.

The Office of Public Health Family Planning and STD programs routinely screen for Chlamydia. During 2005, the Family Planning Program screened 17,748 15-19 year olds and the STD

Program screened 8,257 15-19 year olds.

This Health Status Indicator serves as a monitoring tool and evaluative measure that will help Louisiana focus its resources on continued efforts to bring down the infection rates. By reducing the proportion of adolescents and young adults with Chlamydia Trachomatitis infections, Louisiana can prevent the resulting complications of this infection.

#05B. The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.

/2008/ In 2006, the rate per 1000 women aged 20 through 44 years with a reported case of Chlamydia was 10.56, up from 9.5 in 2005. Public health efforts to lower this rate include the routine screening in Family Planning and STD clinics. During 2006, the Family Planning Program screened 31,570 20-24 year olds and the STD Program screened 27,251 20-24 year olds.

This Health Status Indicator serves as a monitoring tool and evaluative measure that will help Louisiana focus its resources on continued efforts to bring down the infection rates. By reducing the proportion of adults with Chlamydia Trachomatitis infections, Louisiana can prevent the resulting complications of this infection.//2008//

For 2005 provisional data, the rate per 1,000 women aged 20 through 44 years with a reported case of Chlamydia was 9.5, down from a rate of 12.4 in 2004. Public health efforts to lower this rate include the routine screening in Family Planning and STD clinics. During 2005, the Family Planning Program screened 25,630 20-24 year olds and the STD Program screened 13,658 20-24 year olds.

This Health Status Indicator serves as a monitoring tool and evaluative measure that will help Louisiana focus its resources on continued efforts to bring down the infection rates. By reducing the proportion of adults with Chlamydia Trachomatitis infections, Louisiana can prevent the resulting complications of this infection.

#06 A and B. Infants and children aged 0-24 year as enumerated by age, subgroup, race and ethnicity.

Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides Public Health risk and health information based upon these factors.

In 2004, 37% of the state population consisted of children ages 0-24. The indicator provides guidance for age specific programs such as immunization, family planning, school based health and maternity care. For infants 0-1, almost 42% were African American. This data informs and directs social marketing campaigns that address the disparities in this population with higher rates of prematurity, low birth weight and Sudden Infant Death Syndrome (SIDS). /2008/ In 2005, 37% of the state population consisted of children ages 0-24. For infants 0-1, almost 42% were African American.//2008// ***/2009/ In 2006, 40% of infants 0-1 were African American.//2009//***

The Hispanic/Latino population is at almost 3% of the population for all ages of infants and children 0-24 years. After Hurricanes Katrina and Rita, it appears that the Hispanic/Latino population in Louisiana, and particularly New Orleans, is growing. This indicator merits future monitoring of a shift in this population, a shift that would dictate new tools and methods of maternal and child health care. /2008/ In 2005, the Hispanic/Latino population is still almost 3% of the population for all ages of infants and children 0-24 years. Louisiana continues to monitor its shift in the Hispanic population. Many community education programs, particularly in New

Orleans, are now developing print materials in Spanish and English.//2008// ***/2009/ In 2006, the Hispanic/Latino population remains at 3.2% of the total population for all ages of infants and children 024 years old. The state continues to monitor its shift in the Hispanic population.//2009//***

MCH will continue to monitor the demographics of our children in order to evaluate the best provision for appropriate levels of service.

#07 A & B Live births to women (of all ages) enumerated by maternal age, race and ethnicity.

Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides pregnancy information based upon these factors.

This measure provides guidance for age specific programs such as prenatal care, family planning, and direction of resources to the under or uninsured.

Live births are occurring predominately in White and African-American populations. 58% of all births to women ages 19 and under are to African-Americans. 67% of births are to women between 20 and 34 years. In 2004, Hispanic/Latino live births are at about 3% of total births for all ages. After Hurricanes Katrina and Rita, it appears that the Hispanic/Latino population in Louisiana and, particularly, New Orleans is growing. This indicator merits future monitoring of a shift in this population, a shift that would dictate new tools and methods of Maternal and Child health care. /2008/Live births continue to occur predominately in White and African-American populations. Fifty seven percent of all births to women ages 19 and under are to African-Americans. Seventy seven percent of births are to women between 20 and 34 years. In 2005, Hispanic/Latino live births are at about 3% of total births for all ages.//2008// ***/2009/ Live births continue to occur predominately in White and African-American populations. Fifty five percent of all births to women ages 19 and under are to African-Americans. Eighty six percent of births are to women between 20 and 34 years. In 2006, Hispanic/Latino live births are at about 4% of total births for all ages. //2009//***

MCH will continue to monitor the demographics of live births to women in order to evaluate the best provision for appropriate levels of service.

#08 A & B. Deaths to infants and children aged 0 through 24 years enumerated by age subgroup, race and ethnicity.

Please refer to data in FORM 21.
/2009/ Final Louisiana 2005 data shows that there 1,807 total deaths for ages 0 through 24 years, and most were black (938), non-Hispanic (1,748), and ages 1-24 years (1,194). For the 613 deaths in the under 1year age subgroup, 5 were Asian and most were black (361) and non-Hispanic (574). For the 1,194 deaths in the 1-24 years age of subgroup, most were white (600) and non-Hispanic (1,174). For Hispanic deaths (34), most were in the 1-24 years of age subgroup (19). Preliminary 2006 data suggests that total deaths decreased to 1,588. //2009//

/2008/ The 2005 data is provisional. In Louisiana, for children 0-24 years, there were more deaths (1,865) in 2004 than in 2003 (1,670) and 2005 (1,702). Like in 2003 and 2004, more children died in 2005 were less than 1 age (596); African American (881), and non-Hispanic (1,643). In the 0 to 14 years age subgroup (863), most of the children who died were black, non-Hispanic, whereas in the 15-24 years age subgroup (839), most were white, non-Hispanics. Of the 16 Asian deaths, 10 were in the 15-24 years age subgroup and 4 were less than age one year. Of the 32 deaths by

Hispanic ethnicity, 16 were less than age one year, 12 were in the 20-24 years subgroup, and no deaths in children 5-14 years.//2008//

This category of data will assist in directing public health efforts to reduce the number of deaths by addressing risk factors to change behaviors through targeted, preventive interventions, including education and outreach; appropriate allocation of resources; and, if needed, legislation or public policy change. The data also serves as a public health call to action at the local or regional level of the 9 regional MCH Injury Prevention Coordinators and 9 Child Death Review Panels as well as with the SIDS Risk Reduction Initiative, Louisiana SAFE KIDS, and the Louisiana Youth Suicide Prevention Task Force.

Death rates are just one of several measures of our state's health status. Awareness of the leading causes of death can more efficiently and effectively target our efforts and resources toward building a healthier and safer community. Therefore, this HSI serves as a surveillance or monitoring tool to identify the causes of death, risk factors, and the "at risk" groups based on age, race, and ethnicity and to plan preventive interventions through the Child Death Review Panel. The leading causes of death for neonates and infants were conditions originating in the perinatal period (primarily prematurity) and, for 1-24 years, the leading causes were unintentional injuries. As an evaluative measure, by comparing the state's death rates to past rates and to other states' rates, MCH can assess achievement of efforts, appropriateness of efforts, and effectiveness of preventive interventions and allocated resources over time.

#09 A & B. Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race and ethnicity.

Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides Public Health risk and health information based upon these factors.

This data provides guidance for race and ethnicity specific programs such as SCHIP, Medicaid and WIC. The data informs the MCH program in providing advice to other miscellaneous programs. This data informs and directs health and social marketing campaigns that address disparities in this population.

For children aged 0-19 years of age, 44% are in a household with a single parent, the highest national rate. Almost 48% are enrolled in Medicaid and 57% are enrolled in Medicaid or LaCHIP. 8% are served by WIC. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 41st in the nation with a 10% drop out rate. /2008/ For children aged 0-19 years of age, Annie Casey Foundation ranks LA 49th with 42% in a household with a single parent. Almost 48 percent are enrolled in Medicaid and 57% are enrolled in Medicaid or LaCHIP. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 27th in the nation with an 8% drop out rate.//2008// Louisiana's rate of juvenile arrests is 2,828 per 100,000 persons. This is compared to a national rate of 2,443 per 100,000 persons under the age of 18. ***/2009/ For children aged 0-19 years of age, Annie Casey Foundation 2008 Report ranks LA 49th with 41% in a household with a single parent. For teenagers between the ages of 16 and 19 who are not enrolled in high school and are not high school graduates, Louisiana ranks 50th in the nation with the highest drop out rate at 11%. //2009//***

MCH will continue to monitor the demographics of our children in order to evaluate the best provision for appropriate levels of service.

#10. Geographic living area for all resident children aged 0 through 19 years.

Please refer to data in FORM 21.

This measure provides information on the state's residents because it provides Public Health risk and health information by geographic area. Risk to children may be based upon rural or metropolitan living environments.

For children ages 0-19 years of age, 75% live in metropolitan areas with 72% living in urban areas. Almost one third of this population, or 28%, lives in rural or frontier areas.

Following Hurricanes Rita and Katrina, there has been a significant population shift of people from southern Louisiana to inland areas and, perhaps, to rural areas. This bears monitoring to evaluate the best provision for appropriate levels of service.

#11. Poverty levels for the total State population.

Please refer to data in FORM 21.

Two in ten people in Louisiana are at the poverty level with almost one in ten at 50% of the poverty level.

This measure provides information on the state's residents because it provides Public Health risk and health information by poverty level. Risk to individuals may be evaluated based upon poverty level.

Following Hurricanes Rita and Katrina, there has been a significant loss of jobs in Southern Louisiana. This may impact poverty levels within our state. Employment and income bear monitoring to evaluate the best provision for appropriate levels of service. /2008/ Louisiana will continue to monitor the poverty level to evaluate the best provision for appropriate levels of service.//2008//

#12. Poverty levels for all children aged 0 through 19 years.

Please refer to data in FORM 21.

Three in ten children in Louisiana are living at the poverty level with over half of them at the 200% of the poverty level. Children live in higher rates of poverty than the population as a whole.

This measure provides information on the state's children because it provides Public Health risk and health information by poverty level. Risk to children may be evaluated based upon poverty level.

Following Hurricanes Rita and Katrina, there has been a significant loss of jobs in Southern Louisiana. This may impact poverty levels within our state. Employment and income bear monitoring to evaluate the best provision for appropriate levels of service. /2008/ Louisiana will continue to monitor the poverty levels.//2008//

F. Other Program Activities

Infrastructure Building Services

Surveillance
MCH, in conjunction with the Genetics and Lead Section in the Office of Public Health (OPH), has been the recipient of a CDC lead surveillance and prevention grant to establish a statewide population based childhood lead surveillance system. This Program utilizes data from the

surveillance system to develop initiatives in those areas of the State with the highest prevalence of childhood lead poisoning. Initiatives include outreach, public and professional education, and developing partnerships with community agencies and organizations to decrease childhood lead poisoning. A Plan For the Elimination of Childhood Lead Poisoning has been developed and is in the process of implementation. /2007/Funding of the Louisiana Childhood Lead Poisoning Program (LaCLPPP) by CDC, through a cooperative agreement, was renewed for another 5 year cycle through 2010 to continue providing electronic blood lead level surveillance and case management prevention services for children.//2007// ***/2009/ Outreach to pediatric providers emphasized state mandatory child lead screening regulations. //2009//***

Other information systems to monitor health include development of a statewide immunization registry (LINKS), ongoing pediatric nutrition surveillance of children through the Pediatric Nutrition Surveillance System (PDNSS), and a State Child Death Review Panel, which also coordinates and supports Local Child Death Review Panels. ***/2009/ LA Child Death Review received training on the CDC web-base case reporting tool. //2009//***
The CSHS program has implemented recent legislation for a Birth Defects Monitoring Network for surveillance and referral to services. The system began surveillance activities in January 2005. /2008/The Birth Defects Monitoring System currently provides surveillance for approximately 50% of births in Louisiana. The program will receive $230,000 additional state funding and a new position for 2008 to aid in gradual expansion to a statewide system that also provides families with referral information for appropriate diagnosis related services.//2008// ***/2009/ The Birth Defects Monitoring Network received additional funding and is in the process of expanding to cover 70% of births. A healthcare resource guide was developed which will be sent to parents of infants in the system. //2009//***

Coordination/Policy Development
The MCH Program has participated in the development and implementation of the Early Childhood Supports and Services Program. This 6 parish pilot program is an initiative of the Office of Mental Health that establishes a local system for referral of children from birth to 5 years who are at risk for the development of poor mental health, emotional, or developmental outcomes. Children who are screened and found to be at risk for poor outcomes are referred to a local multi-agency coordinating group who develop a plan to provide the supports and services that are needed to improve the outcomes for the individual children and their families. A system for screening and referral of infants in the pilot parishes through the local public health units has been implemented. In addition, a pilot collaboration of the ECSS and EarlySteps Regional Advisory groups has been initiated to reduce duplication in services to children birth to age 3. This program is planned to be expanded to an additional 8 parishes in 2005. ***/2009/ The Louisiana Early Childhood Supports and Services Program currently has 9 sites in 13 parishes. //2009//***

Through the federally funded State Systems Development Initiative for Early Childhood Comprehensive Services Systems (ECCS), the MCH Program has worked with the Louisiana Children's Cabinet and its Advisory Group to establish a framework for the implementation of a system of comprehensive services for the early childhood period. A Needs Assessment focusing on the areas of a Medical Home, Mental Health/Socio-emotional Services, Child Care and Early Education, Parent Education, and Family Support Services had been completed and a Strategic Plan is being completed with plans to begin implementation of the plan in the next year.

/2007/Louisiana's Early Childhood Comprehensive Systems Initiative (ECCS), under the direction of the MCH Program and the auspices of the Governor's Children's Cabinet, has completed an extensive strategic and implementation plan. The strategic plan will enable Louisiana to build a sustainable, comprehensive, coordinated, efficient, and effective system to yield high quality programs and an infrastructure to support and sustain early childhood services.

The MCH Program will have the lead role in the development of Louisiana's MCH Emergency Preparedness and Response Consensus Recommendations for natural and manmade disasters

and mass casualty incidents. The planning process will be a collaborative effort of MCH and EMS-C Programs, through the office of Public Health, the Louisiana Chapter of the American Academy of Pediatrics, the State Perinatal Commission, and key community partners.//2007// ***/2009/ Louisiana BrightStart (ECCS) is completing its second implementation year. //2009//***

Toll Free Hotline
The Maternal and Child Health Toll-free 1-800 number, entitled Partners for Healthy Babies (1-800-251-BABY), provides confidential information for women who call seeking referrals for prenatal care and pregnancy testing. Also provided is information regarding primary and preventive services for children, including services for children with special health care needs, as well as referrals for immunizations and information about LaCHIP and Medicaid. The Louisiana OPH Shots for Tots initiative, in coordination with the Partners for Healthy Babies Project, utilizes the helpline number. Family Planning referrals are also available to callers. The helpline provides referrals to the public and private physicians who provide Title V and XIX services. The Partners For Healthy Babies services are communicated to the public through television, radio, billboards and bus placard advertising. In addition, promotional/incentive campaigns, newspaper articles and public relations meetings with community leaders are also utilized to make the public aware of this information and referral service.

Children's Special Health Services has completed the redesign and transfer of the Part C of IDEA system in Louisiana to the Office of Public Health. In addition to the involvement of parents and stakeholders in redesign activities, other offices in OPH as well as DHH continue to be involved in the Part C Program named Early Steps. EarlySteps staff have participated in the ECCS grant activities. The number of enrolled children in Part C has increased by 43% in the first two years of implementation. Due to the tremendous increase in infants and toddlers served, budget overruns occurred. The program is in the process of a restructuring to make the most efficient use of limited funds. The restructuring of EarlySteps will have significant impact on the system of services for young children in Louisiana. New eligibility requirements and asking families to participate in the cost of services will establish cost containment but limit services to children with a moderate degree of developmental delay. /2008/Following Hurricanes Katrina and Rita the number of children served by the program was decreased due to the mobility of families and providers, with many leaving the state. In the 2008 state application for Part C funding, eligibility criteria were broadened and cost participation of families was eliminated before ever being implemented. The program will be moved to the Office for Citizens with Developmental Disabilities in July 2007, which serves children beginning at age 3 years. The addition of Early Steps will permit OCDD to serve children with disabilities from birth.//2008//

G. Technical Assistance

Technical Assistance needs are described in Form 15. Please see this form for a complete list of anticipated needs.

V. Budget Narrative

A. Expenditures

Successful efforts to redirect funding began soon after the Office of Public Health downsizing in 2001. A plan was developed based on the 2000 MCH Needs Assessment to establish new infrastructure for MCH activities through contract agencies. Since 2001, MCH staff has been establishing partnerships in each region to build MCH infrastructure and services. The success of these efforts is reflected in the increase in expenditures in fiscal years 2002 through 2004. Expenditures have increased to pre-2001 levels.

On Form 3, FY 2004 budgeted figures for Unobligated Balance was zero and the expended amount was $2,017,772. This was due to under-collection in the Program Income category. Program Income was projected to be much higher than was actually collected. This was due to delays in obtaining federal approval from the Centers for Medicare and Medicaid for the expansion of the Nurse Family Partnership Program as a Medicaid covered service in 3 additional regions of the state. Approval was given in the following fiscal year and will be reflected in the FY 2005 expenditure report. This delay in obtaining approval and collections resulted in this amount of unobligated MCH funds expended during FY 2004. /2007/ State Funds: In SFY 2005, fewer State Funds were expended than originally budgeted because the state increased its collection from Title XIX, Medicaid, and was able to use those funds instead. Local MCH Funds: In SFY 2005, fewer Local MCH Funds were expended than originally budgeted because the state increased its collection from Title XIX, Medicaid, and was able to use those funds instead. Program Income: In SFY 2005, Program Income expended was greater than originally budgeted due to changes in Medicaid Billing requirements. The State was able to retroactively bill for newly approved services areas in the Nurse Family Partnership Program, resulting in higher than projected collections. //2007// /2008/ On Form 3, FY 2006 budgeted amount for Federal Allocation was much higher than the expended amount due to hurricanes Katrina and Rita. Office of Public Health lost staff who relocated out of state and contracts were cancelled due to staff leaving Louisiana. Recruiting new staff continues to be problematic in post-hurricane Louisiana. For the same reason, Program Income also had much lower expenditures than the budgeted amount for FY 2006. Also for this same reason Local MCH Funds was higher than the budgeted amount for FY 2006.//2008//

On Form 4, FY 2004 budgeted amount for Pregnant Women was set too low compared to expenditures. Prenatal care and Nurse Family Partnership contracts that began in FY 2003 became fully operational in FY 2004, thus increasing the expended amount. The FY 2004 budgeted amount for children 1 to 22 years was set too high, and the expended amount was consistent with prior fiscal years. The FY 2004 budgeted amount for the Other category was set too low compared to the expended amount, which is consistent with the amount budgeted for Family Planning services. The FY 2004 expended amount for Administration was lower than the budgeted amount due to the overall expenditures being lower than the budgeted amount. /2007/ Pregnant Women: In FY 2005, the budgeted amount for Pregnant Women was set too low compared to expenditures. The number of pregnant women served in 2005 increased. Nurse Family Partnership mothers served and number of visits increased by about 20% each from the previous year, thus increasing the expended amount. CSHCN: In SFY 2005, the Office of Public Health made significant cuts to the budget in the area of contractual services. This was due to overall agency reductions to remain in budget. Because Children's Special Healthcare Services (CSHS) has a large part of their budget in contractual services of physicians, hospitals, parent support and special projects, the program was affected to a significant degree during this time period.//2007//

/2008/ On Form 4, Pregnant Women expenditures was much lower than the budgeted amount for FY 2006 due to the loss of all clinic facilities and providers in the New Orleans region due to hurricane Katrina. Four large prenatal clinics were closed due to the hurricane as well as contracted enabling services for pregnant women in the region. Expenditures for Infants under-1-

year-old were higher than the budgeted amount due to the prioritization of immunizing children in post hurricane Louisiana, resulting in higher expenditures in the Immunization Program. Expenditures for the Other category was lower than the budgeted FY 2006 amount. The Other category is dedicated to the Family Planning Program services and there was a reduction in the number of patients served by over 13% in post-hurricane Louisiana. All Family Planning clinics in New Orleans, including the largest clinic in the state, was closed post-Katrina and continues to be closed. The Administration category also had expenditures lower than the budgeted amount due to the overall decrease in expenditures.//2008//

On Form 5, in FY 2004, expenditures on Direct Services decreased while expenditures on Enabling Services increased. This was due to the increase in Nurse Family Partnership expenditures resulting from program expansion and the continuing decrease in direct maternity and child health services delivered by the Parish Health Units. Expenditures on Infrastructure Building services were less than the budgeted amount due to loss of the reporting mechanism that previously extracted Regional Office of Public Health Infrastructure expenditures from the Direct Services category. /2007/ Infrastructure: In SFY 2005, MCH offered an educational program to every region on expense coding. Nurses and management were encouraged to only code to Child Health and Maternity Infrastructure in limited cases where true infrastructure activities were performed and then by only Regional or Central Office staff. Expended Infrastructure costs were less than those budgeted due to this clarification in assigning expenses. //2007//
/2008/ On Form 5, the expended amount for Direct Health Care Services was lower than the FY 2006 expended amount due to the loss of over half of the population in New Orleans, the loss of clinic facilities, the loss of contract providers and Office of Public Health staff resulting from Hurricanes Katrina and Rita.//2008//

/2009/ On Form 3, FY 2007 budgeted amount for Federal Allocation continued to be higher than the expended amount due to the impact of Hurricanes Katrina and Rita. The attrition in agency and contract staff continued and recruiting staff in the hurricane impacted areas continued to be problematic. On Form 3, FY 2007 Local MCH Funds were budgeted low due to Hurricanes Katrina and Rita, but funding and need increased by the end of the fiscal year.

On Form 4, Pregnant Women expenditures were lower than budgeted amount for FY 2007 due to loss of clinic facilities and providers in the New Orleans region due to Hurricane Katrina. Prenatal clinics funded by MCH continued to be closed during FY 2007. Infant expenditures were lower than budgeted amount for FY 2007 due to loss of agency and contract staff in the areas impacted by Hurricanes Katrina and Rita. CSHCN budgeted amount was set too low anticipating similar reductions as found in other populations. Since there was a drastic loss of pediatric subspecialists in the hurricane affected areas, the CSHCN Program provided a greater amount of direct clinical services because the need was so great. Others expenditure was lower than budgeted amount for FY 2007 due to loss of the largest Family Planning clinic facility in New Orleans. The overall Administration expenditures for FY 2007 continued to be lower than the budgeted amount due to the loss of agency and contract staff due to Hurricanes Katrina and Rita, resulting in lower expenditures for Administration.

On Form 5, the overall expenditures for FY 2007 Direct Health Care Services, continued to be lower than the budgeted amount due to the loss of agency and contract staff due to Hurricanes Katrina and Rita, resulting in lower expenditures for direct services. The overall expenditures for FY 2007 Enabling Services, continued to be lower than the budgeted amount due to the loss of agency and contract staff due to Hurricanes Katrina and Rita, resulting in lower expenditures for enabling services. //2009//

B. Budget

The following services and projects are funded by the MCH Block Grant, Title XIX, patient fees, insurance reimbursements, and local and state funds:

1. Maternity/Family Planning
2. Child Health Preventive/primary services for children birth to 21.

a. Child Health
b. Communicative Disorders Preventive
c. Immunization

3. Children's Special Health Services

a. Children's Special Health Services

The MCH Block Grant supports the state central and regional administrative consultative staff who sets standards of care, develop policies and procedures, train field staff, and provide quality assurance. The amount budgeted for the Central Office of Public Health MCH staff represents the cost of building the capacity of the state to develop community based systems of care. This amount is presented for each of the program components. In addition, other core public health services, direct personal health services, enabling services, and population-based services are included in the following budget. Please see the attachment, Tables 1, 2 and 3, for each type of service for each program component.

The service areas (reporting categories), which relate to preventive and primary care services for children, are provided in Table 2 (see attachment). The amount of funds budgeted in these service areas for fiscal year 2006 exceeds 30 percent of the total MCH Block grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.
/2007/ For Fiscal Year 2007, the amount of funds budgeted for Preventive and Primary Care Services for children exceeds 30% of the total MCH Block Grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. //2007//

A minimum of 30 percent of federal funds received for use in subsequent fiscal years and the associated match will be budgeted for use in programs that provide services for children with special health care needs. The amounts listed on Table 3 (see attachment) will be budgeted for fiscal year 2006. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.
/2007/ For Fiscal Year 2007, the amount of funds budgeted for Children with Special Health Care Needs exceeds 30% of the total MCH Block Grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. //2007//

Sources of State Match and Overmatch Funds
Funds for Maternal and Child Health Services will be obtained from state general funds.

Program Income
Program income comes from Title XIX funds, fees, and third party payers. Table 4 (see attachment) presents the distribution of this income by program component.

Budgeting for Cross cutting Programs
The Office of Public Health is able to associate all expenditures including each staff person's work activity with the correct funding source by a system using reporting categories. The Office of Public Health budget is divided into many service areas, each identified by a reporting category. Most Office of Public Health employees utilize this Reporting Category system to allocate their time and other expenditures to a particular project or service area. This system allows staff working across many programs to allocate their time and other expenditures appropriately.

Use of Overmatch Funds
There is no overmatch that is under the control of the State Title V Agency that is used to match other federal programs.

Fees
Maternal and child health patients receiving services at parish health units and are above 100% of the poverty level are charged $5 per clinic visit and $5 for pharmacy services. Individuals receiving only immunizations, and that are above 100% of the poverty level, are charged $10.00. Family planning patients are charged fees according to a sliding fee scale.

Administrative Costs
Administrative costs are the portion of costs incurred by the following service units that are directly allocated to Maternal and Child Health Services Programs in accordance with Sections 3 and 5 (where applicable) of the Department of Health and Hospitals Cost Allocation Plan:

Office of Assistant Secretary-Management Information Systems (MIS)
Human Resources Section - Policy, Planning and Evaluation
Administrative Services Operations and Support Services
Statewide Costs (Purchasing, Civil Service, Treasurer, Fiscal, etc.)

Collectively these are referred to as Executive Overhead costs. Compliance verification of the 10 percent administrative restriction will be performed and documented by the Fiscal Office at the end of each state fiscal year. The estimated administrative costs for the total budget are $4,376,520 for fiscal year 2005-2006. The estimated Federal share is $1,420,352 or 10.0% of the federal funds requested.
/2007/The estimated administrative costs for the total budget are $4,094,726 for fiscal year 2006-2007. The estimated Federal Share is $1,356,503 or 10.0% of the federal funds requested. //2007//

Administrative Cost Limit - The administrative budget represents no more than 10.0% of the federal funds requested.

/2007/"30 30" Minimum Funding Requirements - The preventive and primary care services for children represent 35.06% of the Block Grant and Children with Special Health Care Needs represent 32.02% of the Block Grant budget. The definitions and descriptions of the services for these project components can be found in the program narratives.//2007//

/2008/ The MCH Block Grant supports the state, central, and regional administrative consultative staff who sets standards of care, develop policies and procedures, train field staff, and provide quality assurance. The amount budgeted for the Central Office of Public Health MCH staff represents the cost of building the capacity of the state to develop community based systems of care. This amount is presented for each of the program components. In addition, other core public health services, direct personal health services, enabling services, and population-based services are included in the following budget. Please see the attachment, Tables 1, 2 and 3, for each type of service for each program component, including the amount budgeted for the service separated into the federal contributions.

The service areas (reporting categories), which relate to preventive and primary care services for children, are provided in Table 2 (see attachment). The amount of funds budgeted in these service areas for fiscal year 2008 exceeds 30 percent of the total MCH Block grant. Thus, there is no need to redirect the MCH program in order to comply with this requirement. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

A minimum of 30 percent of federal funds received for use in subsequent fiscal years and the associated match will be budgeted for use in programs that provide services for children with special health care needs. The amounts listed on Table 3 (see attachment) will be budgeted for

fiscal year 2008. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

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Funds for Maternal and Child Health Services will be obtained from state general funds.

Program Income
Program income comes from Title XIX funds, fees, and third party payers. Table 4 (see attachment) presents the distribution of this income by program component.

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The Office of Public Health is able to associate all expenditures including each staff person's work activity with the correct funding source by a system using reporting categories. The Office of Public Health budget is divided into many service areas, each identified by a reporting category. Most Office of Public Health employees utilize this Reporting Category system to allocate their time and other expenditures to a particular project or service area. This system allows staff working across many programs to allocate their time and other expenditures appropriately.

Use of Overmatch Funds
There is no overmatch that is under the control of the State Title V Agency that is used to match other federal programs.

Fees
Maternal and child health patients receiving services at parish health units and are above 100% of the poverty level are charged $5 per clinic visit and $5 for pharmacy services. Individuals receiving only immunizations, and that are above 100% of the poverty level, are charged $10.00. Family planning patients are charged fees according to a sliding fee scale.

Administrative Costs
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Office of Assistant Secretary-Management Information Systems (MIS)
- Human Resources Section - Policy, Planning and Evaluation
Administrative Services Operations and Support Services
Statewide Costs (Purchasing, Civil Service, Treasurer, Fiscal, etc.)

Collectively these are referred to as Executive Overhead costs. Compliance verification of the 10 percent administrative restriction will be performed and documented by the Fiscal Office at the end of each state fiscal year. The estimated administrative costs for the total budget are $4,376,520 for fiscal year 2006-2007. The estimated Federal share is $1,356,503 or 10.0% of the federal funds requested.

Administrative Cost Limit - The administrative budget represents no more than 10.0% of the federal funds requested.

"30 30" Minimum Funding Requirements - The preventive and primary care services for children represent 38.7% of the Block Grant and Children with Special Health Care Needs represent 32.0% of the Block Grant budget. The definitions and descriptions of the services for these project components can be found in the program narratives.//2008//

/2009/ "30 30" Minimum Funding Requirements - The preventive and primary care services for children represent 35.4% of the Block Grant and Children with Special Health Care Needs represent 30.0% of the Block Grant budget. //2009//

Maintenance of State Effort - The State Office of Public Health intends to pursue and expects to obtain state general funds for Maternal and Child Health Services that equals or exceeds the level of such funds provided during state fiscal year 1989. Compliance verification will be performed and documented by the Fiscal Office at the end of each state fiscal year. The state support in state fiscal year 1989 was $6,207,276.

Allocation for Activity Conducted to Continue Consolidated Health Programs
The following federally funded programs were consolidated by the Maternal and Child Health Block Grant in fiscal year 1981 1982 in Louisiana:

1. Maternal and Child Health Program;
2. Crippled Children's Services Program (in Louisiana called Children's Special Health Services);
3. Supplemental Security Income/Disabled Children's Program
4. Lead Based Paint Poisoning Prevention Program (previously funded only in City of New Orleans in Louisiana);
5. Genetic Diseases Program (incorporated previous funds for sickle cell disease at Flint Goodridge Hospital in N.O.);
6. Sudden Infant Death Syndrome (SIDS) not funded in Louisiana; and
7. Adolescent Pregnancy Program not funded in Louisiana.

The following state funded programs in effect in Louisiana at the time of Block Grant Legislation in 1981 were also incorporated into the Maternal and Child Health Block Grant:

1. Genetic Diseases Program statewide screening for certain inherited disorders such as PKU, hypothyroidism, and sickle cell anemia.
2. Sudden Infant Death Syndrome (SIDS) Program follow up and counseling of affected families statewide.

Special Projects In Effect Before August 31, 1981

1. Maternal and Infant Care Project discontinued;
2. Children and Youth Project discontinued;
3. Family Planning absorbed into general Family Planning Program; Title V funding for Family Planning Program is budgeted at $1,925,000;
4. Dental Health For Children reduced services current funding for Dental Services for Children's Special Health Services New Orleans District Office;
5. Neonatal Intensive Care absorbed by Louisiana State University Medical Center in Shreveport.

An attachment is included in this section.

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.